By: Jason McGowan

From time to time the specialist teacher or clinical educator will find themselves sitting with a child for whom there are few, if any, tricks left in the bag.

This is the child that has had the proverbial 'kitchen sink' thrown at them and they have not responded.

These children have become known as *treatment resistors*. This term is not unique to education but is also used in medicine and other areas of health science. The question is sometimes asked, "Are treatment resistors children who actively resist intervention by non-compliance"? The answer is a resounding no. In fact the opposite is true. These children are more likely to be fully compliant and highly motivated, often persisting at tasks much longer than the teacher's expectation. Yet they experience little or no success relative to their efforts.

By and large these children seem to fall into two categories. The first is the 'classic' Dyslexic child who has extremely severe symptomatology. The second category is the child who is also reasonably severe relative to Dyslexic symptoms but who also has coexisting conditions. The top three offending conditions are: attention and concentration problems, high anxiety and fatigue. These three pathologies are also the top three reasons why students drop out and fail to complete intervention.

However, even these three particular difficulties need to be quite severe to render the child unresponsive to intervention.

Consider the case of Jessica:

She is an 11 year old girl. She has a strong family history of significant Dyslexia. She has no wider developmental problems but does have severe short term and working memory difficulties. Medical investigations including an EEG have not revealed any important facts. She has trialled a number of medications without great success but remains under the care of a developmental paediatrician. Her general memory problems are likened to "Black Hole Brain". This is a crude clinical term to convey the notion that despite significant repetitive and drill-like intervention the child cannot remember even the most basic information. It is like the material has disappeared into the proverbial 'black hole' within the brain. Her mother described it as follows: "Jessica has many cupboards inside her brain. She locks the information away in the cupboards and although we know it is there she can't find the cupboard to get it out"

Jessica seems to know how to read and spell certain CVC words but within minutes after revising such words she spells the word 'dog' as 'loj'. This is after months of intervention that focuses on synthetic combinations like VC and CV blends as well as CVC words.

Jessica reads orally with assistance on a daily basis and she engages in a repetitive reading drill for four or five days a week. Yet at any given time she cannot read aloud the familiar portions of text that she has been studying.

Jessica makes mild progress of 9 months in 12 months in the first bout of intervention. Somehow this seems satisfying and the decision is made to engage in a second about of intervention 3 months later. Again an intensive, systematic and cumulative type intervention is delivered on a one on one basis. The quantity and quality of instruction is in line with evidence based interventions. But again on a test retest basis Jessica fails to improve. In fact in the final stages of the second bout of

intervention she makes the same errors she made almost 18 months previous. To the specialist teacher Jessica is a complete enigma. She is inconceivably confused relative to written language and behaves as if she has had no remedial assistance whatsoever.

Jessica is thus considered a treatment resistor.

Treatment Resistors essentially present two problems to the clinical educator. The initial problem is how to identify such a child before treatment commences. The second and perhaps more painful problem is what do you then do for a child for whom even state of the art intervention has not worked?

Research to date has not been able to provide the clinician or specialist teacher with a solid enough model on which to predict which students are likely to resist intervention.

There is of course a moral dilemma associated with this. If a predictive model was available and it was possible to say that a certain student would not respond to intervention than such a child could be considered, on that basis, as beyond hope. This seems to be a drastic and dire position to take especially relative to young children. However, on the other hand, what is the emotional cost to a child and the child's family when they are subjected to years of significant intervention only to discover that they have essentially wasted their efforts.

The resolution of such a dilemma may not be close. However to the impaired learner and their justifiably concerned parent and to the committed teacher the accurate identification and prediction of student ability and performance remains a necessary pursuit.

Thankfully research and practice are beginning to merge in such a way that the quality of teacher instruction and recovery of poor readers is entirely achievable.

Clinically speaking there seems to now be a critical mass of information and strategy available that allows even the most profoundly disabled learner a chance of at least moderate recovery.

The treatment resisting child will probably still come along from time to time but more than ever there is real sense that the degree and nature of resistance is declining.