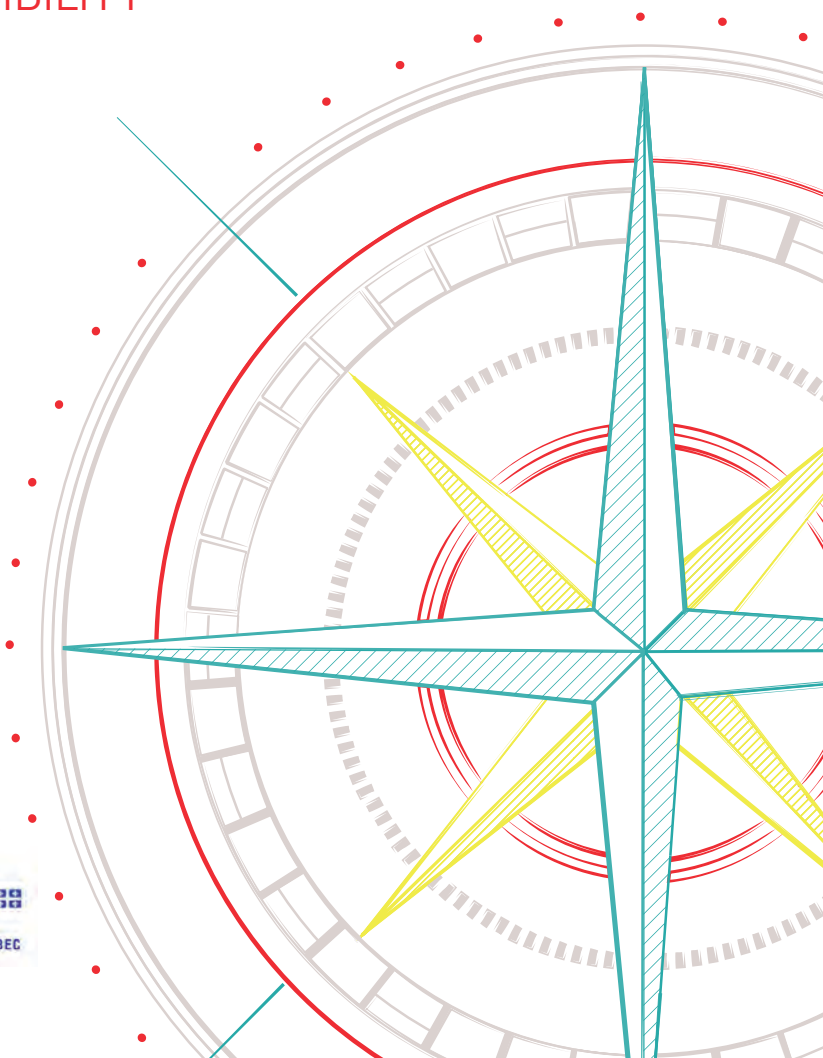
SciencesPo

INNOVATIVE PEDAGOGY AND SUPPORT GUIDE **COGNITIVE DISABILITIES AND DISABLING MENTAL HEALTH CONDITIONS**

TOWARDS IMPROVED ACCESSIBILITY IN HIGHER EDUCATION

2nd EDITION



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COOPÉRATION FRANCE-QUÉBEC

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PREFACE

All of the terms used in this document should be understood in a generic way, without any particular distinction in terms of gender.

The testimonies cited and the specific situations described have been made gender neutral to protect the anonymity of those concerned.

Certain data has been intentionally presented with limited detail to avoid the identification of specific cases.

Where medical terms have been used, care has been taken to use for only those employed in official classifications or for those that have the broadest consensus. Their use does not in any way address questions relating to the delivery of health care, which does not fall within the scope of this guide. The medical response to any pathology is specific to the individual patient and is integral to the relationship of trust between the patient and the doctor managing the treatment in compliance with the Code of Medical Ethics.

The use of certain terms is the subject of recurrent debate between practitioners, experts, campaigners, support groups and the persons affected. Such questions are neither debated nor resolved in this document. For example, the expression 'student with autism', sometimes used in preference to 'autistic student', is understandable on a semantic level because it does not reduce the individual's identity to his or her disability. The same applies to the commonly used term 'students with autistic spectrum disorders'. Nevertheless, these terms remain contested, giving rise to significant reservations and objections in principle.

The most commonly used terms are employed here in a completely neutral way.

In the original French language version of this guide, the vocabulary used by the French High Authority for Health has been given general preference.

Sciences Po

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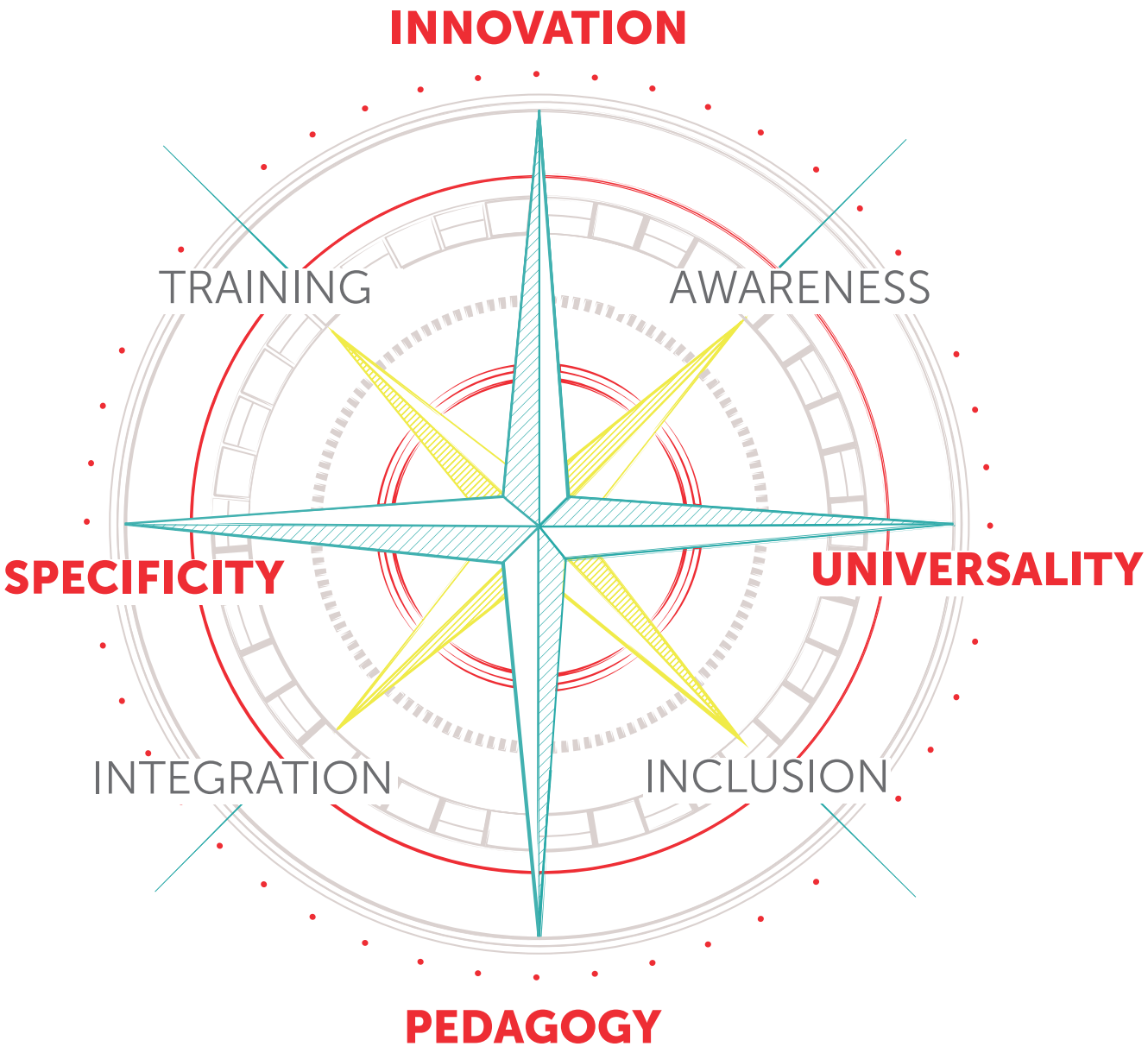
- English language version - December 2018


INNOVATION
TRAINING
AWARENESS
SPECIFICITY
UNIVERSALITY
INTEGRATION
INCLUSION
PEDAGOGY

"STUDENTS WITH DISABILITIES DON'T NEED TO BE MOLLYCODDLED, **BUT THEY DO NEED TO KNOW THAT THEY CAN REACH OUT IF THEY NEED A HELPING HAND ALONG THE WAY."**

Autistic student, November 2015

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FOREWORD

The worlds of work and education today share a common challenge: an increasing need to accommodate and integrate students and graduates of all ages with hidden disabilities (e.g. autism, specific learning difficulties, mental health conditions), some of which require particular types of assistance. Most current measures support classroom learning with methods such as the allocation of extra time and the provision of human and technological assistance, but few solutions concern teaching methodology and the evaluation of learning.

Since 2016, Sciences Po has been involved in a research project that has resulted in the development of a number of pedagogical innovations relating to invisible disabilities. On the basis of its own trials, and analysed alongside research conducted by other universities, notably in Canada, Sciences Po has developed methodologies that can be reproduced by any institution.

Building on these results and the experimental work started in September 2017 with McGill University in Canada, which included the launch of a course based on the principles of metacognition, Sciences Po, the Agefiph and the FIPHFP aim to assess the needs of students with disabilities and to seek appropriate and innovative pedagogical solutions.

This original approach from Sciences Po aims to identify appropriate ways to increase support for students with cognitive disabilities and disabling mental health conditions. This guide aims to promote good practice among teaching staff. The objective is to disseminate the details of the experiments carried out and the full results of the research to the entire education sector (schools and universities), and beyond into the continuing professional development sector.

The stakes are high: students with learning disabilities and other disorders have higher drop-out rates and difficulties transitioning to the workplace. It is vital that we understand their additional support needs. Facilitating the design of inclusive teaching and learning produces benefits for the entire educational community.

The Agefiph and the FIPHFP, in collaboration with Sciences Po, are taking action to confront the employment challenges faced by people with disabilities. In assisting the passage between the world of education and the world of work, we aim to contribute to the creation of a more inclusive society.

Marc DESJARDINS
Director of the FIPHFP

Didier EYSSARTIER
Managing director of the Agefiph

INTRODUCTION

OUTLINING THE APPROACH

This work is an accurate reflection of the underlying principles and values that guide the provision of support to students with cognitive disabilities or mental health conditions at Sciences Po. Like the compass that appears in the above image, they orient and inspire for action to be taken on a daily basis to ensure that students have a fulfilling educational experience and are prepared for a successful transition to the world of work.

Similarly, the recommendations, suggestions, and all of the practical solutions described in this guide have been tested. The research does not claim to be exhaustive, but the many examples of its practical application lend weight to its effectiveness.

This guide is dedicated to creating a better higher education experience for students with cognitive disabilities and disabling mental health conditions. It is intended for use by extended educational teams:

- Teaching staff, irrespective of their status (whether permanent, temporary or visiting);
- University administrative staff;
- Disability Service staff;
- Senior management.

In general, this guide is intended for use by all teaching personnel who support learners with cognitive disabilities and disabling mental health conditions, to be adapted depending on the individuals concerned.

This guide aims to provide a toolkit for the formulation of educational responses to complex disabilities, or to the specific circumstances of very vulnerable students whose difficulties constitute a major obstacle to the pursuit of their studies.

The overall performance of an educational institution is best evaluated and can be built upon in a calm and supportive environment. To this end, increasing inclusion must be a key objective.

Improving awareness and providing practical information to our educational teams is therefore a prerequisite for offering a truly accessible education to people with cognitive disabilities or mental health conditions. However, the nature of these health conditions also requires the development of support measures in the form of appropriate adjustments to teaching/learning methods and assessment procedures.

The relative invisibility that characterises cognitive disabilities and disabling mental health conditions makes it particularly difficult to adequately cater to them in the university system. Numerous situations remain unidentified, under-reported, insufficiently taken into account or simply ignored.

The indicators are, however, well known: students dropping out temporarily or permanently, absenteeism, mental ill-health and a visible impact on educational performance.

This situation causes unnecessary suffering for the students concerned, as well as a feeling of relative powerlessness for teaching and university staff who often lack the necessary resources to respond to such difficult situations.

Beyond the question of invisibility, which creates problems in understanding and responding to these issues, other aspects have been considered in shaping the recommendations proposed in this guide:

- the variety of circumstances that exist, often for the same condition;
- the nature of the measures to be implemented, particularly when they represent a considerable challenge for teachers who have rarely received training for such issues;
- the effect of certain disabilities or conditions on teaching methods and assessment procedures, which can partially negate standard support measures;
- widespread negative perception caused by lack of awareness and misconceptions of the disabilities and conditions concerned.

All too often, students with cognitive disabilities or disabling mental health conditions do not receive the appropriate support for their situation from the outset. Insufficient awareness among educational teams is compounded by poor communication of good practices, even if their implementation does not require specific skills.

The contributions of neuroscience, cognitive science and developmental psychology now offer us a better understanding of learning processes. In particular, they demonstrate that brain function differs from one individual to the next. These differences, which result from genetic, perinatal or environmental factors, can have a significant impact on learning processes (attention, memory, reading, writing, adaptation).

This does not in any way affect intelligence. However, the use of standardised teaching methods suited to the neurotypical majority can disadvantage or exclude those with neuro-atypical profiles. It is therefore understood that disability, in relation to cognitive and mental health conditions, is largely the product of interactions in a context, rather than a constant.

This evidence underscores the need for the education system to elevate the development of all by making diversity an asset.

This is not only an issue for the most vulnerable students: everyone has differences, regardless of how these manifest, that can only be brought to light in an open environment, extending the boundaries of possibility. This is one of the ways in which human progress occurs.

It is not simply a compassionate or altruistic educational approach that supports well-identified needs or satisfies a greater common sensitivity to the obstacles encountered by vulnerable groups in their "participation in social life in its broadest sense"[1] ; nor is it the result of an ethical or moral concern. It is, most importantly, a way to improve excellence in teaching. Indeed, pedagogical innovation is the best way to boost collective creativity and strengthen social ties whilst giving everyone the opportunity to excel.

In this respect, teachers should bear in mind that students with cognitive disabilities and disabling mental health conditions have considerable potential that is all too often overlooked. Despite the difficulties they experience, they manage to pursue their studies in higher education with remarkable merit and sometimes with brilliance. They display talents that must be fully recognised if they are to achieve results that meet their aspirations.

Finally, this guide aims to illustrate to the educational community that offering additional support for specific disabilities through pedagogical innovation translates into direct benefits for all students, with or without disabilities.

Therefore, the themes addressed here resonate with the inclusive approach of 'accessible to all' and encourage an approach that makes disability a powerful agent for positive change.

1. 2005-102 Disability Act.

PEDAGOGICAL INNOVATION: FACILITATING ACCESSIBILITY FOR ALL

In recent years, the prominence given to pedagogical innovation has provided the opportunity for major structural changes in the field of education. Originally inspired by the rapid development of digital technologies, it has become one of the major areas of reform in the education system.

Pedagogical innovation was defined in a 2014 report from the French National Innovation Council for Educational Success (chaired by the sociologist Didier Lapeyronnie) as: "An innovative practice is a pedagogical activity characterised by close and sustained attention to the students, to the development of their wellbeing, and to the quality of learning. In this way, it promotes and supports the democratisation of education.

Building on the creativity of the teaching staff and all students, an innovative practice is also based on a change-management methodology.

None of these elements is enough alone, but together they enable the educational team to enrich the action it takes using the resources available, making each action an innovative practice in both its delivery and its effects [2]."

This ambitious definition presents a dynamic, collaborative and robust interpretation, involving each stakeholder in the quest for progress. Moreover, this theory, which involves direct intervention in the classroom, leads to the qualitative development of practices from which everyone can benefit, giving pedagogical innovation a decisive role as a vector for inclusion.

2. For an Innovative School: summary of the work of the National Innovation Council for Educational Success, Ministry of National Education, Higher Education and Research, delivered on November 10, 2014. http://cache.media.education.gouv.fr/file/11_Novembre/91/4/2014_rapport_cnire_web_366914.pdf

FOCUS ON THE NOTION OF INCLUSION

"The notion of inclusion emphasises the relationship with others: in its broadest sense, it affirms that every individual has a place in social life and that this place must neither be diminished, nor disregarded or subject to conditions...

The notion of inclusion regards diversity not as a challenge for society, but as a source of social well-being, economic development and a vehicle for the realisation of human rights.

In the name of the founding principles of the law, it affirms that every individual, regardless of his or her individual characteristics, has the right to live according to his or her aspirations and that, as long as he or she is given the possibility to do so, contributes to the common good.

[Inclusion involves] standing out from the form of education that is satisfied with a form of integration that 'normalises' and considers the 'integrated' as mere visitors rather than fully fledged members of the educational community[3]."

3. Inclusive school for students with disabilities: accessibility, academic success and individual development, Research report, Conference for the international comparison of school inclusion of disability (28-29 January 2016), The National Council for School System Evaluation, January 2016. http://www.cnesco.fr/wp-content/uploads/2015/12/rapport_handicap.pdf

The presence of cognitive disabilities and disabling mental health conditions and their impact on the teaching/learning process offers particularly fertile ground for pedagogical innovation, in the sense of the inclusive approach enshrined in the 2005-102 Disability Act.

1) Their presence requires attention to be given to what happens inside the classroom, in particular how knowledge is transmitted and learning evaluated.

2) Their presence encourages a pedagogical approach that uses a much broader range of participatory methods in the study environment.

3) Their presence also raises questions that concern the entire student population: the pace of learning; assessment; the organisation of tasks; stress management; the relationship with performance; concentration; memorisation; the comprehension and assimilation of knowledge; writing and speaking skills; group work; the ability to work autonomously; career guidance; and the use of new technologies.

Despite the difficulties highlighted above being particularly acute for students with cognitive disabilities and disabling mental health conditions, they are not specific to them. Consequently, the search for solutions is a potential source of improvement in pedagogical practices that will benefit the wider student population.

Accessibility is therefore based on the idea that responding to the needs of students with disabilities can serve as a springboard for universal educational innovations.

Factoring disability into the core development of pedagogical innovations fulfils more than just the objectives of the approach: it provides qualitative benefits in terms of well-being for all stakeholder groups (students, teachers, university staff), democratises studies for all and ensures excellence in the provision of knowledge.

Nevertheless, this approach to pedagogical innovation is of particular interest to students with cognitive disabilities or disabling mental health conditions. By democratising mainstream education, the need for individualised, partially adapted and stigmatising support measures is reduced.

It also makes it possible to create an environment that normalises diversity, similar to that experienced in the broader social environment, transforming the wider perception and understanding of disability. As this work prepares the citizens of tomorrow for the world that awaits them, the stakes are high.

Indeed, rather than adapting educational provision to reduce barriers without helping to overcome them, pedagogical innovation can provide opportunities to develop direct solutions to the problems that hinder the process of learning.

THE LEGAL FRAMEWORK

The 11 February 2005 Equal Rights, Opportunities, Participation and Citizenship for People with Disabilities Act has profoundly changed the legal framework for the provision of support for people with disabilities.

The definition of disability enshrined in the act is set out in article 114: "For the purposes of this Act, a disability is any limitation of activity or restriction of participation in social life in its broadest sense sustained by a person in his or her environment due to a substantial, lasting or permanent impairment of one or more physical, sensory, mental, cognitive or psychological functions, multiple disabilities or a disabling health disorder."

This definition has had several effects:

- it made it possible to recognise mental health conditions, whether chronic or temporary, as falling within the scope of disability. This was not the case before;
- it introduced the notion of cognitive disability at a time when common use of the term was still relatively new;
- it now considers people with disabilities to be in a dynamic relationship with their environment, whereas previously individual circumstances were considered in a specifically defined, hard and fast way;
- it opened up the possibility of adapting the environment to accommodate people with disabilities, where previously the environment was still widely considered to be a constant;
- it recognises an inclusive approach to disability management, favouring, as much as possible, non-differentiation through 'access to everything for all'.

REMINDERS ABOUT THE VOCABULARY

***The Guide for the Support of Disabled Students at University* from the Conference of University Presidents (2007, 2012) is considered a benchmark for academic institutions and provides some useful definitions that are worth highlighting[4].**

DISABLING CIRCUMSTANCES

The notion of disabling circumstances concerns all people, whether or not they are said to be disabled. Disabling circumstances result from the mismatch between a person's abilities, their immediate environmental needs and a task to be performed or an objective to be fulfilled. The terms 'disabled person' and 'disabling circumstances' should not be confused.

ACCESSIBILITY

Accessibility measures (accessibility of the built environment, information, knowledge, etc.) are general measures that are taken independently of the actual presence of people with disabilities in the area concerned (in this case, on university premises). Examples include the provision of ramps, lifts, e-book subscriptions, the installation of TV-enlargers, access to online information, etc. The accessibility measures put in place are useful for everyone. For example, self-opening doors are greatly appreciated by people carrying out deliveries to the university.

SUPPORT MEASURES

Support measures are individual and linked to specific personal needs. Examples include the adjustment of a curriculum, the use of a French language/French sign language interpreter or allowing extra time to put together responses in exams.

4. *The (French language) Guide for the Support of Disabled Students at University* produced by the Conference of University Presidents (2007, 2012). http://www.cpu.fr/wp-content/uploads/2013/11/Guide-handicap-web2.pdf

With regard to higher education, article 20 of the 2005-102 Disability Act advises that: "higher education institutions enrol students with disabilities or disabling mental health conditions according to the provisions governing access on the same basis as other students and ensure their access to education by putting in place the adjustments necessary to the students' circumstances in the coordination, development and support of their studies."

The impact of this article is significant as it outlines a set of rules to be implemented via university rectors, vice-chancellors, and the heads of academic institutions who govern the disability policies of their respective institutions.

"As the guarantors of compliance with the law within their universities, the heads of these institutions endeavour to define and make their respective establishments' policy clear with regard to disability. They have the political and operational tools to fulfil this legal obligation:

- by explicitly including disability concerns in the job description of a member of the university management team;
- by guaranteeing all aspects of accessibility within their institution (accessibility of the built environment, access to information, knowledge, student life, etc.);
- by ensuring that the procedure for accommodating and supporting disabled students is publicised;
- by ensuring that the structure for accommodating and supporting disabled students within their university is adequately facilitated and funded;
- by appointing, where appropriate, disability ambassadors whose role is to communicate the university's disability policy within its different bodies.[5]"

More recently, certain additional legal provisions were specified in the ministerial circular 2015-127 of 3 August 2015.

Any modifications to courses of study and changes that affect examinations must be authorised either by the Inter-University Service for Preventive Medicine and Health Promotion (SIUMPPS) or the Departmental Centre for Disabled People (MDPH).

This measure greatly limits the ability to propose suitably adapted pedagogical solutions if a student, sometimes ambiguously, reports his or her disability to academic staff and/or the institution's disability service in order to access additional support but refuses to allow circumstantial information to be shared with teaching staff. Often, especially with regard to cognitive disabilities or disabling mental health conditions, fear of stigmatisation and a refusal to accept categorisation according to certain representations of disability are the reason for the under-reporting of these conditions.

However, several solutions are possible:

- a more down-to-earth discussion about disability can help convince the student that it is in their best interests to inform teaching staff;
- information about a particular disability can be provided to teachers, accompanied, if necessary, by appropriate pedagogical advice, while allowing the student to remain anonymous;
- teachers can be informed in advance about a particular student and given general advice on the required support measures to be put in place, but without mentioning the nature of the disability.

The mainstreaming of a range of pedagogical innovations and good practices is preferable as it also resolves many of these individual issues, in addition to improving accessibility for all.

5. *The Guide for the Support of Disabled Students at University* produced by the Conference of University Presidents (2007, 2012). http://www.cpu.fr/wp-content/uploads/2013/11/Guide-handicap-web2.pdf

THE INFORMATION PROVIDED TO EDUCATIONAL TEAMS
ABOUT SPECIFIC SITUATIONS: HOW DOES IT WORK?

According to the law, no one can force anyone to divulge his or her disability.

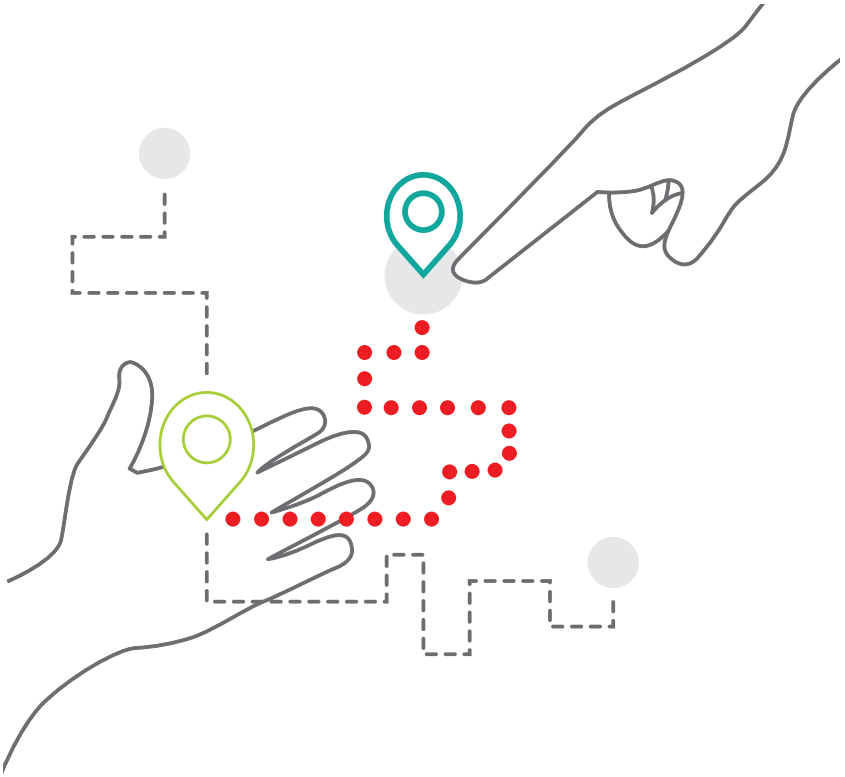
This means that students are free to decide whether or not to inform their institution of their disability or disabling mental health condition.

Nevertheless, before each examination session, students are regularly reminded of the deadline for making their individual support needs known.

A disability or mental health condition can be declared at any time during the journey through higher education, from admission to the final year of study.

Students wishing to declare their disability should contact their institution's disability support service to make themselves known and present the documentation required for their request to be considered.

If a student prefers that teachers not be made aware of their circumstances, the information remains confidential. This respect for confidentiality is a right guaranteed by law and cannot be circumvented.



PART I
EDUCATIONAL RESOURCES

ISSUES TO BE AWARE OF

KEY ISSUES FOR INFORMING AND RAISING AWARENESS

To establish appropriate pedagogical innovations that facilitate accessibility it is essential to provide information and raise awareness among all educational staff, both academic and non-academic. This issue is key to improving practice.

The way that knowledge is transmitted and assessed cannot be changed without the full support of those responsible for it.

The principal challenge to this approach is to combat persistent prejudices, stereotypes and unfounded fears before convincing teaching staff of the legitimacy and value of the proposed pedagogical innovations.

These feelings, often resulting from a general lack of awareness, create a situation where bad practices persist, however unintentional this may be.

Even if a student's disability is invisible or hidden, when appropriate information is provided to teaching staff, the disability is taken into account and catered for.

THE ROLE OF THE TEACHER: TO BE OBSERVANT

It is necessary to reflect upon the collective role of teachers, and what they are capable of delivering.

Teachers in higher education are often perceived as being set apart or distanced from their students.

Greater understanding of the complex circumstances of vulnerable students will help establish certain principles that are still far from being widely acknowledged, and they will gradually become standard professional practice.

First of all, it is the responsibility of the teaching staff to be attentive to all students under their watch, both in terms of their academic work and their personal wellbeing (within the limits of respect for their respective positions). During the course of their teaching work, staff should be particularly vigilant about distributing the required student workload evenly and avoid concentrating it too much on periods of intense activity (the middle and end of semesters).

This is beneficial to the wellbeing of all students, many of whom show signs of anxiety before important deadlines but is especially beneficial for those students with disabilities who often have to intensify their efforts, leading to over-tiredness. Similarly, it is useful for teachers to be vigilant with regard to performance anxiety, which affects many learners.

It is vital to recognise the role that teachers can play in identifying students in difficulty. Teaching staff is ideally placed to notice any unusual behaviour, including signs of discomfort, fatigue, and other symptoms that may be apparent.

While teachers may understandably find some symptoms distressing, it is important to encourage them to report situations, and to trust their instincts when they do so. It is preferable to take preventive action wherever possible. Vigilance at this stage is key, as early intervention can result in more effective support mechanisms.

The role of a teacher can be summed up anthropologically as the process of transmitting the gift of knowledge, investing in the well-being and the future of others. It is, essentially, an act of altruism.

It is therefore appropriate that teachers be invited to fully invest their skills for the benefit of their students as future citizens and professionals.

For example, if a teacher notices that a student is very anxious, is exhibiting troubling behaviour, or suspects that they are experiencing a serious problem, they should not attempt a diagnosis. Their role is not to replace that of a doctor.

Depending on the particular circumstances and according to the teacher's instincts, one of two approaches may be adopted:

- they can report it to the appropriate staff member, who will then be able to monitor the situation (e.g. check whether absenteeism is more frequent than usual) and, if necessary, suggest an appointment with the student;

- they can tactfully express their concerns to the student. If the student divulges information about a health issue, the teacher is then bound by strict confidentiality rules. However, based on the relationship of trust that has been established, they can encourage the student to consult the institution's health service or see a doctor. If the health issue is already being treated and is still having an impact on the student's academic work, the teacher can advise the student to contact the Disability Support Service to find out about the measures that can be put in place to modify courses of study and help in assessment situations.

EXAMPLE OF A REPORTING MESSAGE

"Dear xxx, I'm writing to express concern about [write the first name and only the initial of the surname], a student in my Tuesday morning class. For the past two weeks, s/he has been withdrawn, sitting at the back of the class and seeming sad or preoccupied, although s/he has been actively participating in classes since the beginning of the semester. S/he arrived late for the most recent class and was clearly very tired. What has made me even more concerned is that she sent in an assignment by email three days late, telling me that she was unable to finish it on time due to a 'personal matter'. I have looked over the assignment and my initial impression is that it is of significantly lower quality than the previous one, which she delivered on time and was given one of the highest grades in the group. You may already have been alerted to a change in her circumstances. Nevertheless, I wanted to point out these observations to you in case you have not been informed. I remain at your disposal if I can be useful. Kind regards,"

EXAMPLE OF CONVERSATION

- **Teacher:** [First name], do you have a few minutes? I'd like to discuss something with you.
- **Student:** Okay, but I've got another class in a quarter of an hour, so I can't be late.
- **Teacher:** Don't worry, this won't take long. Well, I'm a little worried about you and I wanted to discuss it with you. I've noticed that you've been quite withdrawn for the past couple of weeks, whereas you were joining in really well before, and you didn't send me your last assignment by email yesterday as planned. I've also got the impression, perhaps mistakenly, that you're worried about something.
- **Student:** I'm sorry, I'll definitely send it to you tomorrow. I've had something on my mind, but it's almost sorted.
- **Teacher:** If you've got a problem, you can always talk to me in confidence.
- **Student:** Thanks, but I'm fine.
- **Teacher:** Okay. If you've got a problem, but you don't want to talk to me about it, that's fine. I can put you in touch with the right people within the university to help you. Don't wait for the situation to get worse if you have a major problem. We can always find solutions, but it's easier to help when we can step in earlier rather than later.
- **Student:** I know, but it's not easy to talk about.
- **Teacher:** Is it something to do with your health?
- **Student:** Yes, kind of. In fact, the thing is, I was suffering from depression during the first semester. I thought it was getting better, but now, with all the work piling up, I'm feeling really stressed and for the last couple of weeks, I've been totally overwhelmed. I don't know what to do to keep my head above water.
- **Teacher:** I understand better now. Have you seen a doctor?
- **Student:** Yes. I'm seeing a psychiatrist. I saw him last week and he increased the dose of my antidepressant. I'm not feeling as anxious as before, but I'm exhausted and I can't get out of bed in the morning. I can't keep up with the workload any more.
- **Teacher:** This isn't something you should have to face on your own. You're the only person who can make the decision, but it's really important to ask for help, especially if you are receiving medical care. You'll probably be entitled to some academic support.
- **Student:** No, I don't want to stop.
- **Teacher:** Under no circumstances will anything be imposed upon you, but some some adjustments can be made to help you get through this period in the best way possible. For example, you can ask for extensions to assignment deadlines, which would help you spread out the workload. If necessary, you might also be eligible for a time extension during the exams.
- **Student:** What do I have to do for that?
- **Teacher:** Get in touch with the university health service or the Disability Support Service.
- **Student:** But I'm not disabled.
- **Teacher:** It's not about labelling you, but the fact is that your current situation is disabling in relation to your studies. That's why, while you're getting better, you're entitled to support measures approved by the university medical service, via the health service and the Disability Support Service. They can explain the steps you need to follow and provide you with the necessary support. I also recommend that you see your academic advisor as soon as possible to discuss your circumstances. If you want, and only with your agreement, he or she can, for example, let your teachers know that you're going through a difficult time. A little bit of kindness and attention will help you get back on your feet.
- **Student:** Thank you very much. I didn't know all of that.
- **Teacher:** You're welcome, and don't hesitate to tell me if you have any concerns about anything you need to do.
- **Student:** Okay, thanks. I'll let you know.
- **Teacher:** Great. Off you go, don't be late. See you next week.
- **Student:** Bye, and thanks for your help.

MEDICAL CARE AND THE STUDY ENVIRONMENT

Educational teams should not interfere in any way with the therapeutic care of students with cognitive disabilities or disabling mental health conditions; these fall within the exclusive competence of the medical profession.

SYMPATHY VERSUS EMPATHY

It is often difficult to find the right attitude to take with a student in a vulnerable situation. Expressing empathy may seem to be the right approach because it reflects a form of understanding, a clear recognition of what the student is experiencing, and it is considered to be an altruistic response.

However, this may lead to acts of involuntary stigmatisation, which in a classroom environment may create an uncomfortable atmosphere, particularly for a student who is sensitive to others.

It may have the opposite effect to that desired and may become anxiety-provoking and unsettling by singling out the student within the group.

It is therefore always preferable to replace a visible empathic approach with one of invisible sympathy, based on the need to be constantly kind and attentive, but with a good measure of discretion.

DEPARTURE ABROAD/RETURN FROM ABROAD

Particular attention should be paid to students doing internships or mobilities abroad as part of their course.

When organising a stay abroad, it is essential to ensure that students don't choose a destination that is inappropriate in view of any particular difficulties or individual circumstances.

Major time-zone differences, particularly to the east, can, for example, have significant negative effects on the well-being of students with severe mental health conditions. Similarly, it is essential not to let students with known or suspected addiction problems leave for countries where the laws are particularly repressive; this is the case for drugs, but also for alcohol, due to the high risk of incidents occurring while intoxicated.

Upon their return, many students have difficulties re-adapting, and this may be exacerbated by other difficulties that should also be considered, such as reduced motivation after an extraordinary experience, difficulties in resuming a sustained pace of work, or returning to very different schedules.

ADVICE

It is important never to act in a way that amounts to singling out, in words or actions, a student with a cognitive disability or disabling mental health condition from the rest of the group in the class.

If necessary, at the end of a session, the student may be discreetly asked to stay behind for a few minutes to discuss an issue related to his or her individual circumstances.

HOSTING FOREIGN STUDENTS

It is also important to pay particular attention to the well-being of foreign students.

Distance from their family, friends and/or loved ones may make them vulnerable, especially in the event of unforeseen difficulties. Additional factors such as unfamiliar surroundings and biorhythm disturbances may trigger depressive episodes or other disorders for which vigilance is required.

These students may be unwilling to share the truth about any difficulties they are experiencing with their families (fear of disappointment, socio-cultural reasons, etc.) and they may be unaware of the host institution's support services, with a resultant delay in seeking help.

It is important to be aware that overseas student mobility is perceived as a valuable experience, is highly regarded by students' friends and family, and is often a cause for celebration before their departure. All this makes it difficult for the student to admit that the experience is proving challenging without feeling guilty.

It is therefore a good idea to make it clear to all foreign students that asking for help is completely normal and to inform them of the services available to them should they find themselves in need.

AN ESSENTIAL ISSUE TO WATCH OUT FOR

Awareness amongst teaching staff is fundamental to providing appropriate support for students with cognitive disabilities and disabling mental health conditions. It is also essential to fostering the right pedagogical attitude towards vulnerable as well as non-vulnerable groups.

However, being well informed about the impact of a disability in a learning context also leads to the risk of pigeonholing people according to learned information.

This is an understandable result of increased awareness, and one that stems from good intentions.

Nevertheless, constant reflection is necessary to avoid labelling and categorising students, which can simply reduce them to a collection of symptoms.

Each person's way of managing their disability is different, depending on their background and experience. The way in which difficulties are expressed also varies from one person to another, over and above the core features and severity of the condition.

1) Each student's situation should be understood individually, taking into account personality and the particular circumstances of their active relationship with the study environment.

2) **Never predict the ability of a student to carry out an exercise, overcome a problem, or be able to meet a requirement without having first discussed this with them.** As such, establishing (academic or other) criteria that have not been discussed with the student concerned should be avoided.

Good pedagogical practices cannot exist without mutual consent.

THE IDEAL INCLUSIVE COURSE

SINGULARITY VERSUS UNIVERSALITY

Supporting students with disabilities involves adopting practices that are acceptable to the individuals concerned while maintaining universal student equality, which is their right, including the most vulnerable.

Just how far can we go in making pedagogical adaptations for some students without creating differences that are unacceptable to either party, whether for fear of stigmatisation or of unfair advantage?

It is difficult to provide a general answer to this complex question. However, it should be noted that problems of this kind are less frequent in an environment where difference is no longer seen as an exception to the norm.

This also highlights the importance of raising student awareness of disability and how to respond to it in order to change preconceptions. Students with cognitive disabilities and disabling mental health conditions are also more open to reporting their difficulties in a more inclusive environment, which positively affects their education and wellbeing.

The same applies with regard to coursework and assessment.

COMPUTERS AND INTERACTIVE LEARNING

New technologies drive significant innovations in the field of learning. In just a few years, advances in digital technologies have led to numerous, rapid developments and this shows no sign of abating.

However, these changes are not always beneficial, and need further examination to determine the advantages they bring. For example, the large-scale introduction of computers into classrooms raises questions about the associated benefits.

The use of computers in lectures has allowed students to fully capture the content provided, which they can then edit, enrich or reorganise according to their needs and preferences. This potentially enables more active learning than was previously possible.

Yet, in situations where interaction, sustained attention, and increased use of comprehension skills are more important, using a computer to take notes is of more questionable value.

Many of the teachers interviewed noted that screens effectively create a barrier between them and their students in some small-class interactive situations. Some teachers also found a relative decrease in spontaneous oral participation. This can be partly explained by the fact that working on a computer can distance individual students from the rest of the class, particularly if they are tempted to connect to the internet or work on something else.

A large number of students experience attention problems, not all of whom experience them as a symptom of a particular disability (e.g. ADHD or autism spectrum disorders). Attention problems can often be explained by tiredness and other cumulative factors such as information overload or excessive sensory stimulation. The advisability of proposing different levels of computer use according to the nature of the teaching requires further consideration.

PROCEDURES FOR SHARING DOCUMENTS

EXPERIMENT
CLASSES WITHOUT SCREENS

One teacher imposed a ban on the use of computers during his classes in four of his smaller groups (Second Year and Master's).

This rule could be detrimental to students for whom the use of a computer is recommended to compensate for a disability (e.g. dyspraxia-dysgraphia). In order to limit any possible stigmatising effects, the teacher made a point of raising the issue of difference before imposing the ban, then invited students to disregard the instruction if they felt it was necessary.

When he initially announced the ban, some students questioned its use or value. These students informed the teacher of their reluctance to take part in the experiment. The main argument put forward was that they were used to working with a computer and that they would therefore waste time re-typing their handwritten notes outside the course.

The teacher asked his students to fill out a course evaluation at the end of the semester and the results were enlightening.

In the end, the vast majority positively evaluated the experiment and acknowledged a positive effect on their attention and interest in the course, some confessing that they often did something other than follow the class when hidden behind their screen.

Several students also explained that after several sessions, they voluntarily stopped using computers during other courses, having clearly seen the benefit that this brought them (improved understanding, therefore more time to catch up outside class on key gaps in learning, etc.).

EXPERIMENT
FLIPPED CLASSROOM METHODS OR CLASS OVERVIEW?

One teacher made her course material - with additional descriptive content - available in electronic format before a small class session. She projected a summary document during the class and subsequently made it available to the students.

The students, including one with a cognitive disability, were then consulted for their views on this practice.

The vast majority of students found this method of providing course material to be very positive. Some even saw an effect on the way the session played out (more participation, more attention, richer interactions with the teacher).

In general, the students interviewed preferred this flipped classroom approach, as it allowed them to take ownership of the class content in advance. They obtained additional value from the course in terms of explanation and understanding as a result.

This is particularly true for students with cognitive disabilities or disabling mental health conditions, where the vast majority support this practice as it reduces, for various reasons, the stress of classroom interaction.

EXPERIMENT
EDITABLE OR LOCKED DOCUMENT?

At the very beginning of the semester, one teacher posted a first-year lecture online in a locked PDF format. He later made the material available to his students in a modifiable version.

The students, none of whom had declared a disability, were then consulted on the effectiveness of the practice. Around 100 students responded to a quick survey.

Most of the students found it interesting that the course material was shared in this way. Many explained that this approach allowed them to focus on the explanations in class, taking just a few additional notes by digitally annotating the document provided by their teacher.

EXPERIMENT
ELECTRONIC OR PAPER VERSION?

1) One teacher distributed her course material in paper form in addition to projecting it during a small class session.

   The students, including one with a cognitive disability, were then consulted about this practice.

   The idea was to see if this provided additional value to the students, particularly in terms of concentration, by eliminating the need to copy details from the projected document.

   None of the students, including those with cognitive disabilities, perceived any additional advantages in having a paper version if the teacher had already shared the class material in electronic form, ideally before the lesson and in a format that could be modified to suit their own individual learning needs.

2) A language teacher distributed his course material in paper form in addition to projecting it during a small class session.

   In the two previous sessions, he had projected the course material, but without distributing it in paper form.

   Over the course of the three sessions, the students learned a new grammatical concept and practised applying it.

   The students, none of whom had declared a disability, were then consulted on their views of the two different approaches.

   The students preferred the paper distribution method because it allowed them to concentrate on the explanation without having to take notes on the grammar rule, and to add notes to the paper document only where they felt it was necessary. In addition, they then had the document and explanations on hand for carrying out the follow-up exercise.

   The method was therefore useful for learning the concept studied.

ACCESSIBILITY OF DOCUMENTS: HOW TO MODIFY A TEXT OR DOCUMENT TO MAKE IT MORE ACCESSIBLE.

- Use Arial font 12 or 14 (depending on the nature of the document).
- Choose 1.5 or double line spacing (depending on the nature of the document).
- Increase the default spacing between characters, if necessary.
- Space the paragraphs by inserting a paragraph break after each meaningful development.
- Insert a paragraph break for each section and subsection.
- Isolate a table, graph or map on a page, making sure that annotations are clearly displayed.
- Clearly label tables, diagrams and other visuals.
- Use clear nomenclature to distinguish sections, points and lists.
- Number the pages by indicating their total number to make it easier to find them in the document.
- Highlight all titles and distinctive points in bold.
- Highlight relevant words in bold.

EXAMPLE OF FORMATTING CONTENT

BEFORE

For nearly 15 years, Sciences Po has been pursuing an active student diversity policy by prioritising equal opportunities. In 2008, the institution set up an ambitious program for students with disabilities: the creation of a Disability Support Service. This program was at the heart of Science Po's 2009-2012 four-year agreement with the Ministry of Higher Education and Research, which set the institution the objective of enrolling 100 disabled students by 2012. This objective was achieved. In the 2017/2018 academic year, the institution hosted no less than 270 students with disabilities, an increase of almost 10% in one year

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EXPERIMENT

COMPARATIVE MODIFICATION OF COURSE MATERIAL ADAPTED FOR AN AUTISTIC STUDENT

A common misconception largely invalidated by this experiment is that the adaptation of course materials for autistic students penalises other students.

One teacher used the flipped classroom method for one of her course sessions and offered her students two versions of the preparatory document: one classic and one adapted. The document required the students to analyse text excerpts, make statements that applied knowledge, and comment on data presented in a graph. The revised version of the document was put together on the basis of comments from an autistic student who assessed the original version in advance, and the advice of an autism expert.

The objective of this experiment was to gather the comparative opinions of the group of students concerned, none of whom have autism.

Some of the students pointed out that the revised version of the document was more detailed and therefore less easy to read spontaneously than the original version. However, none of them found that the revised version rendered the work requested more complicated. They concluded that it was neither better nor worse than the other version. Two students even admitted that the revised version, which was more explicit about what was expected, had helped them understand what was being asked when answering the questions.

The teacher found that the revised version of the document was of interest because it "made it easier to understand by explaining more precisely what was expected".

However, she pointed out one limitation: it could result in limiting "the ability of students to go beyond what is explicit." In other words, "to deduce and induce from a level of information... things that make it possible to acquire experience that varies the way in which a problem is looked at."

Examples of practical and easy things to implement:

- visually space out a document to avoid information overload;
- use a generously spaced and highly structured layout;
- number everything (document pages, related course sessions, sections, questions, sub-items) clearly;
- ensure that a logical progression is maintained in the different parts of the document;
- explain all acronyms, even when they seem obvious;
- add a glossary, where possible;
- reiterate a definition when it should be drawn upon to respond to a question;
- indicate each reference to a text, table, quotation etc., so that they can be identified;
- avoid sentences with several intuitively related ideas;
- check that the formulations used do not include allusions or insinuations that need to be interpreted ('why' rather than 'how', etc.).

EXPERIMENT
TEXT ADAPTATION IN A COURSE WITH A DYSPRAXIC STUDENT

In one of his smaller classes, a teacher offered the students, one of whom was disabled (dyspraxia and associated dyslexia), an adapted version of the compulsory course texts.

The experiment took place over two sessions. For the first session, the appropriate text had been modified; for the second session, where the students had been asked to read two texts, only one had been modified to allow comparison.

The revised versions of the texts were produced on the basis of standard recommendations.

The students were not informed in advance of the experiment, but they were subsequently consulted on the value of the adapted versions.

The student with a disability had not identified that the texts had been adapted to make them more accessible, but he clearly found a benefit when reading:

"I didn't quite understand why, or at least not in a precise way, but I realised that it had taken me less time to work through both texts."

"Usually it's complicated with texts that have a narrow font size and very busy pages. It's difficult for me to develop an understanding. I get confused. With both texts, it was easier for me to initially skim through them, find my way around and start seeing what they were about. I usually need to read the text through twice to reach that point, but this time it was good from the first read through. The bold words and clear separations helped me a lot. After that, it was also easier to do a closer reading."

Most of the other students in the group also noted that the two revised texts were easier to read and understand, especially in comparison to the second, unchanged text from the second session.

It can therefore be concluded that providing modified texts makes them more reader-friendly for the majority of students. This has a positive effect on their comprehension and, consequently, on the assimilation of knowledge.

[Dyspraxic student, April 2016]

ASSESSMENT

Research into the accessibility of education has primarily focused on the ways in which knowledge and skills are transmitted. This approach can be seen as logical given the importance of the transition into the professional world. Where better inclusion of people with disabilities is concerned, the use of pedagogical innovation has essentially focused on knowledge transmission. Progress in this area has been significant but still requires ongoing effort.

Consequently, assessment and the evaluation of learning have so far been little explored in relation to disability, although this is a growing area of interest. While efforts are being made to make education and the professional world even more accessible, the methods for assessing knowledge and evaluating learning remain largely unchanged. People with disabilities therefore have better access to knowledge and skills but their academic success is measured using often unsuitable methodologies.

This creates a paradox because evaluation is not simply a way of verifying learning. **As part of a process of continuous assessment it enables learners to situate themselves in relation to others and become aware of their own progress, particularly with the development of self-assessment techniques (dynamic pedagogy). When used correctly it helps build confidence and shape ambition, as well as broaden the field of possibilities.** More generally, by giving official recognition to an objective level of attainment, it ultimately determines a student's professional opportunities.

Some commonly used assessment methods remain partially unsatisfactory and are frequently of little pedagogical value for disabled and non-disabled students alike. Many are out-dated in relation to developments in teaching and learning and, as such, they create additional obstacles for learners with disabilities without achieving their intended objectives.

One such example is standardised English tests, which can be discriminatory for several types of disabilities. Disability support organisations have successfully lobbied for students to be exempt from such tests, leaving educational institutions in the position of having to find an alternative option. This solution cannot be recommended in the long term, given the increasing number of students with cognitive disabilities and disabling mental health conditions.

The stakes are high, particularly in terms of the success of students' future transition into the professional world, and therefore merit a significant investment of resources from the educational community.

SPECIAL ATTENTION FOR CERTAIN DISABILITIES

Students with cognitive disabilities and disabling mental health conditions often have a complex educational path and are at greater risk of dropping out. They therefore need support and reassurance from their teachers in terms of academic expectations and the appropriate strategies to achieve these goals.

Providing appropriate methodological advice is therefore essential, whether it is advice relating to the subjects taught or to the mastering of skills associated with learning.

In regard to the evaluation and assessment criteria it is important to select exercises that measure universal competencies (excluding the obstacles brought about by certain disability situations). This process must also consider any practical constraints to the correct completion of the work: difficulties speaking in public for a student with post-traumatic stress disorder; difficulties making structured and coherent essay plans for students with severe cognitive impairments; difficulties getting started for students with ADHD; or difficulties in work planning and fatigue management for students with mental health conditions.

‘LEARNED HELPLESSNESS’
FEEDBACK ON AN ENLIGHTENING EXPERIMENT

A famous experiment carried out in various contexts highlights both the mechanisms of ‘learned helplessness’ and its rapid internalisation. The experiment concerns high school pupils and higher education students.

A teacher distributes a worksheet to the whole class and asks them to solve three anagrams.

The exercise must be carried out under the supervision of the teacher and therefore, the learners have to wait for his or her signal to begin searching for the three solutions, one after the other. They are invited to raise their hands when they have solved the first anagram.

Within a few seconds, the right half of the class has their hands up, while the second half is still thinking.

The teacher invites the whole class to move on to the second anagram. The same situation as before is repeated: only the right half of the class have their hands up after a short time while the other half has failed to solve the enigma.

The teacher then invites the whole class to move on to the third anagram, which contains more letters than the two previous ones. A short while later, a large part of the right half of the class has their hands up, while only a few from the other half have found the solution.

The teacher then explains to the whole class that he distributed two different word lists. The right half had three easy words, although the third was a little longer. The left half of the class had letters that could not be used to form a word for the first two anagrams, and this placed them in a situation of systematic failure.

The conclusion of the experiment is striking. While the third word was identical in both lists, learners in the half of the class that had failed to solve the first two anagrams had more difficulty finding the third solution than the others. Within a few minutes, they had experienced ‘learned helplessness’.

A debriefing with learners who take part in this experiment always reveals the same type of comments. When the first half of the class was able to solve the first two anagrams without any difficulty, the learners from the other half gradually felt ‘uneasy’, ‘frustrated’, ‘worried’ and/or ‘irritated’ about seeing them succeed. They also said that they ‘lost confidence’ when faced with the success of the others in contrast to their own failure

ASSESSMENT PROCEDURES TO AVOID

Where disability is concerned, some evaluation methods are much better at measuring the incidence of a disability rather than the mastery of skills, the acquisition of competencies or the assimilation of knowledge.

Imposing discriminatory or partially accessible exercises without adjustments for students with disabilities effectively limits their ability to perform.

This leads to learned helplessness: a profound internalisation of the feeling of failure that has lasting, detrimental effects on self-esteem and self-confidence. Evaluation methods such as time-limited multiple-choice tests or group work where the teacher does not monitor or carry out a clear distribution of tasks should therefore be used as little as possible, or even be avoided altogether if they don't play a significant role in attaining the educational objectives.

Anything that does not enhance progression over time in terms of increasing expertise, the capacity for autonomous reasoning, or the practical application of knowledge needs to be reconsidered and redeveloped using pedagogical innovation.

SOME EXAMPLES TO FOLLOW

Increasing numbers of teachers are adopting assessment methods whose grading rationale is always based on standard criteria, as with handwritten exams, but which are innovative in terms of their format and characteristics.

The aim is to maintain high expectations while allowing all students to express their talents through original approaches that can also be a source of motivation and even a source of complementary learning (the concept of formative assessment).

These include thematic projects, practical examples (role-play, real-life case studies, etc.), and approaches where innovative development has resulted from the research on flipped classroom techniques.

It should be noted that interest and enjoyment encourages investment and the desire to do well, and results in increased attention spans. The students, whether or not they are disabled, will be able to excel when an exercise is stimulating and enjoyable rather than laborious and uninteresting.

Offering a choice of assessment can also help combat procrastination and promote a sense of direction and self-confidence

SHOULD ASSESSMENT SOMETIMES BE WAIVED?

For teachers setting evaluation exercises that have accessibility issues, a common and largely compassionate reaction is to suggest that the students affected be exempt from all or part of the assessment procedure, or even that their grades be adjusted.

However, rather than demanding preferential treatment that sets them apart, most people with disabilities prefer not to be differentiated from their peers. Assuming that someone is unable to perform is a discriminatory approach that denies people the right to participate. Assessments should be inclusive and rewarding for everyone.

Inclusion also emphasises that disability is not a barrier to the pursuit of excellence. Everyone has an interest in being encouraged to achieve his or her very best.

It is only by surpassing oneself and pushing the boundaries of possibility that individuals can fully develop. From this perspective, people with disabilities are no different from anyone else.

EXPERIMENT
ADAPTATION OF A METHOD FOR ASSESSING KNOWLEDGE

A teacher uses a traditional method of assessment such as a multiple-choice test. The exercise takes place during a class session over a limited time of 30 minutes.

The exercise is potentially inaccessible to three students with learning disabilities.

Procedure implemented:

- Negotiation between the student and the teacher to determine an alternative evaluation method that is not discriminatory, i.e. that should be carried out discreetly under the same conditions as the rest of the group.
- A short questionnaire is sent to the three students suggesting an alternative exercise that is adapted to their needs:

  1) Do you agree to specific modifications being made to the classroom assessments for your needs (this does not apply to the exams at the end of the semester)?

  2) If yes, can you please tell me whether you experience dual task attention deficit?

  3) If yes, do you have any particular difficulties in responding to multiple-choice questions?

  4) If yes, could a shorter multiple-choice question test be appropriate for you to undertake at the same time as the other students or would you prefer a different exercise?

  5) Do you need additional time to read documents?

Results:

The questionnaire confirmed that the three students could not complete multiple-choice question tests as they have difficulty with reading and/or speed of performance.

Their preference was for another assessment exercise rather than a shorter multiple-choice test, to take place at the same time as the other students so as not to be discriminatory.

Two 15-minute questions related to the theme of the multiple-choice test were prepared for the students concerned.

The document with the questions was distributed in class at the same time as the one with the multiple-choice test so that the three students were not set apart from the rest of the group. One of them, who was allowed to use a computer due to dyspraxia, sent his answers directly to the teacher by email. This wasn't an issue for the other students because they were already aware of this additional support measure.

In a subsequent evaluation, the teacher chose to dispense entirely with the use of multiple-choice questions. As a matter of principle, he interviewed the students using the inclusive method.

USE A BALANCED GRADING SYSTEM

Considering disabled students' circumstances when attributing grades doesn't mean expecting less from the students concerned, who are often particularly deserving in light of the efforts they make every day to cope with their difficulties.

Inclusive assessment ensures that these students have the same opportunity to succeed as others.

The use of sympathetic grading - which is relevant if the teacher is sufficiently informed in advance of the impact of specific disabilities in the learning environment - can be reassuring, helping to avoid discouragement and prevent students dropping out.

However, grading must remain balanced if it is to be fair to all students and rewarding for those with disabilities.

"It all starts with young people, a fact that is too often overlooked. One day the youth will reproach us, not for having asked too much of them, but for having underestimated them and not asked more of them... We think that young people are indifferent while the reality is that they can no longer hope for anything in life. They depend on us to build, I hope, a society where the fundamental values of life, intelligence and human consciousness will be affirmed[6]."

6. Television address by François Mitterrand, Palais de l'Élysée, Wednesday 23 March 1983.

PRACTICAL ADVICE

- **Reward efforts** and offer constructive criticism, particularly if the assessment exercise poses a specific difficulty with regard to the disability in question.

- **Do not unduly sanction a delay in returning homework exercises:** the most important thing is that the work is completed, which can be a very costly investment iin terms of emotional or cognitive effort and the consequent fatigue.

- **Point out mistakes but do not overly penalise spelling for dyslexic and dyspraxic students.** It is possible to remove 1 or 2 points from the grade without it being discouraging.

- **Focus on the quality of the content** rather than penalising students with cognitive impairments for clumsy or faltering structures.

- **Do not overly penalise awkwardness or a lack of eloquence in public speaking or presentations;** bear in mind that the emotional and cognitive effort involved in asserting oneself in front of others is sometimes considerable.

- **Encourage everyone to express themselves in class,** but do not place too much value on oral participation, as this is discriminatory.

- **Establish a margin of progress rather than a predefined absolute level** when grading.

METACOGNITION

In the field of education, metacognition concerns the awareness of one's own learning processes, understanding and performance in order to regulate learning more effectively (modification, reassessment, optimisation).

The aspects covered by metacognition, beyond the knowledge of the cognitive function, are numerous:

- awareness of one's own learning processes;
- memory capabilities;
- understanding one's mistakes;
- active reading;
- skills in constructing an argument and critical thinking;
- ordering ideas;
- cognitive bias;
- planning and organising work (individual or collective);
- combating procrastination;
- preparing for and completing examinations (revision, good understanding of the academic expectations, engagement with knowledge, time management);
- oral expression and self-assertion;
- stress and performance anxiety management.

In pedagogical practice, teaching based on metacognition gives importance to collective discussions and practical scenarios, with immediate feedback on experience.

For example, one teacher gave his students a set of documents to read, instructing them to summarise and prioritise the key thematic ideas. In preparation for carrying out the exercise, he spent some time looking at active reading strategies (techniques, advice, etc.) with the students. Before outlining these strategies, he asked the students to read a short text and give a group presentation explaining how they had each approached the document (author, source, etc.) in order to extract the pertinent information.

He was then able to draw on the practices used to validate or correct them and suggest strategies for improvement.

Observing their peers in this kind of practical exercise makes it easier for students to become aware of how they function themselves, to adjust where necessary, and to internalise and put in place appropriate strategies that make practical sense.

These principles are central to the metacognitive approach, can be mobilised for both disciplinary learning and methodological learning, and are transferable to other research and practice contexts.

Why promote the development of learners' metacognitive skills?

The students of today have an evolving relationship with knowledge.

Technology has significantly changed access to information in all its forms, making it more accessible, diffuse and abundant.

Higher education is still struggling to comprehend the extent of the effects of this profound change, despite its resulting difficulties and the changing skills profile of learners being well observed.

Methodological difficulties are particularly recurrent for learners: in the prioritisation of ideas; the management and processing of information (evaluating the reliability of sources, 'fake news' etc.); the construction of consistent arguments; the application of theory to practical reasoning; and the development of critical thinking skills.

The main pedagogical challenges are in addressing these key issues in knowledge assimilation beyond the field of education.
We must equip future generations with the self-awareness required to monitor and reassess their own abilities in a context of accelerated technological progress that requires significant adaptive skills.

Fostering the development of students' metacognitive skills plays an important role in achieving these objectives.

Metacognition, or the awareness of one's own cognitive processes, is used in this context to help students develop an understanding of how they each acquire knowledge, skills and perspectives.

In particular, this requires a robust methodological approach in terms of learning strategies and a pedagogical approach that promotes autonomy (helping students to better manage their own intellectual capabilities).

Based on research advances in neuroscience, cognitive psychology and educational sciences, metacognition is a continually evolving field that attracts growing interest.

In Singapore, metacognition has been introduced as an educational standard throughout the public primary and secondary education system, while its dissemination and use in various settings is increasing around the world.

JOINT RESEARCH
CONDUCTED BY SCIENCES PO AND MCGILL UNIVERSITY

Sciences Po has established a research partnership with McGill University (Montreal), supported by the Samuel de Champlain Programme, which promotes strategic academic cooperation between France and Quebec. This partnership is dedicated to pedagogical innovation in relation to cognitive disability and disabling mental health conditions as part of a universal inclusion process for the benefit of all. Within the framework of this partnership, one of the experimental components of the research undertaken concerns metacognition.

The experiment, initially developed at Sciences Po, consisted of setting up a workshop entitled, "How to learn better and develop personal learning strategies". It took the form of an elective course over one semester, consisting of of 12 two-hour workshops. The content was developed by an expert in close collaboration with the research team, which also facilitated the workshops in conjunction with other contributors.

An initial cohort of around 20 students took the course in the first semester of the 2017/2018 academic year, followed by a second cohort in the following semester. In both cases, students enrolled on a voluntary basis, availability of places being the sole constraint. There was no selection process. However, for the second cohort, the course description mentioned that the workshop could be of particular interest to students with learning and/or cognitive difficulties.

For the second semester cohort, some of the course content was modified to take into account the observations made during the previous semester.

The objective of the course was to provide the students with the tools required for processing, developing and communicating ideas, which would enable them to evaluate their own work strategies. After an introduction to metacognition and the cognitive functioning processes involved in learning, they were given the opportunity to gain a more conscious understanding of their own working methods, particularly in terms of attention, memorisation, planning and stress management.

They were also placed in interactive sessions aimed at developing their reasoning skills (both oral and written), self-evaluation skills, critical thinking skills (introduction to methodological biases) and their understanding of the mechanisms used in manipulating opinions.

The experiment was conducted using a survey protocol that combines longitudinal cohort monitoring (with a control group), declarative (yes-no) questionnaires completed at different stages, observations, and qualitative interviews.

The course is also to be held at McGill University, with the goal of undertaking a comparative analysis of the data.

Metacognition has significant social, political and economic implications for education and vocational training, particularly in the context of accelerating international competition in technological innovation. The advent of the knowledge economy and the development of artificial intelligence are increasingly transforming learning needs. Horizontal social relations founded on notions of autonomy and adaptions to individual needs are another emerging trend at all levels of society.

It is to these challenges that the use of metacognition in education responds by making the learner more of a strategic and informed participant rather than a subject.

Metacognition is an integral part of a universally inclusive approach. Through the development of appropriate learning strategies, it enables dynamic and reasoned knowledge acquisition and better management of educational resources. It also has a beneficial effect on knowledge retention and concentration levels.

It also promotes better work practices, e.g. time management, which consequently improve self-confidence and reduce fatigue and stress.

All of this has a positive impact on all students, providing resources and practical tools for those living with cognitive disabilities or disabling mental health conditions.

PRACTICAL ADVICE

Developing self-evaluation and self-correction skills has been shown to have significant pedagogical value, particularly for the improvement of autonomy in learning.

These skills are directly related to metacognition and merit being given particular attention, in addition to the more general advice offered about learning strategies (working methods, organisation, time management, revision advice, etc.).

Any educator can provide metacognitive instruction by applying the following principles:

- encourage learners to verbalise their intellectual steps;
- encourage learners to reflect on the strategies they use at each stage of the learning process and to evaluate their effectiveness;
- support learners in the development of their metacognitive skills through group discussions and repeated exercises (thinking time when planning and performing a task, regular self-assessment, constructive feedback from peers and the teacher);
- explain the metacognitive approach used in teaching (questions, reasoning steps, strategies used, etc.);
- be open to new, reflexive approaches.

CAREER GUIDANCE AND THE TRANSITION TO THE WORKFORCE

FROM CAREER GUIDANCE TO THE WORKFORCE

Choosing the right career path is always a challenge and involves committing to a particular decision for the long term. For students with visible or invisible disabilities, the importance of getting this right is magnified by the more particular scrutiny to which they are subject. Each career choice leads to an 'analysis of the disability market' phase where feelings of competence can give way to a fear of rejection.

The time students spend in higher education plays an important role in helping them identify a suitable career path and facilitating the subsequent transition to the professional world.

Within a lifetime, the time spent as a student is short. However, and particularly for learners with disabilities, it is an essential period for building confidence, laying the groundwork for a robust and sustainable career path and providing the resources necessary to manage a career.

The education sector and employers must work alongside one other to bridge the gap for the benefit all young people in education. As such, the goal of getting students into employment is a primary objective of education and forms an integral part of learning support.

ACTIVE CAREER GUIDANCE

Career guidance is an essential part of the journey through higher education, particularly where temporary or permanent disability exists.

It is advisable to provide disabled students with individual career guidance to help them focus on:

- defining their fields of expertise (academic strengths, personal interests, extra-curricular commitments, specific interest in different areas of their studies, etc.);
- their motivation and willingness to persevere in a career where disability may be a challenge. Equally, they should be helped to avoid rejecting attractive professional opportunities on the pretext of inaccessibility.
- the reality and feasibility of their career plans by helping them network with professionals, business leaders and experts.

  This will help them explore their interest in their chosen field, and the ways their skills can be adapted to it. It is also an effective way to address any fears or concerns that may present obstacles;
- ensuring that they are aware of the codes and practices of their chosen profession and any subtleties that they will need to consider, particularly if the student has an autism spectrum disorder. To avoid demotivating experiences, guidance for students wishing to pursue careers in the banking or consulting sectors must be prepared in advance with support from professionals in the field of disability career support.
  In some situations, it may be appropriate to offer the student training in certain social skills, such as standard dress codes or expected verbal behaviours.

ASSISTING ACCESS TO THE WORKFORCE

Once a student's career objectives have been defined, transition into the world of employment can be undertaken incrementally. At this point, specific support must be provided to guide students with disabilities through the job search process.

Making the transition to the workplace is difficult when a disability is long-term: the student needs to learn how to talk about their disability and the limits it imposes while emphasising the strengths arising from any difference. This is a very ambitious goal when talking about post-adolescents or young adults. Moreover, there is the question of official recognition of a person's disabled status in the workplace: is it to be recommended or should it be discouraged for certain types of disabilities?

On this very personal subject, where every individual must be free to express their preferences and choices, some realities can be outlined.

In France, disabled worker status (RQTH) is granted by the *Commission des Droits et de l'Autonomie de la Personne Handicapée* (Disability Rights Commission or CDAPH), part of the *Maisons Départementales des Personnes Handicapées* (Departmental Centre for Disabled People or MDPH) or the Social Security system and grants important rights to employees and civil servants (medical examination backed up by occupational therapy, workstation adjustments, facilitated access to teleworking, etc.). Today, the status of people with disabilities is no longer taboo in the public sector or in many private companies. However, it is the personal decision of every individual concerned whether or not to declare his or her disability.

From a legal point of view, students or employees are not obliged to make their disability status known. From a practical point of view, holding disabled worker status enables employees to benefit from a range of accessibility and support measures within the workplace such as workstation adjustments and mobility assistance. This can prove invaluable when a significant alteration to someone's state of health occurs.

The transition to employment can therefore be facilitated, provided the right doors are opened. A few tips can be useful for this:

- many larger companies have an established disability policy that promotes, among other things, the recruitment of students with disabilities. Some companies have established partnerships with schools, higher education institutions and apprenticeship training centres to offer preferential access to internships and job opportunities;
- some smaller companies may also have a dedicated disability policy, offering the services of staff members that have been trained in this area. These disability-friendly schemes can help smooth the transition to employment;
- to prepare for the job search, it is always advisable to contact a company's disability service to find out about recruitment procedures (internships and jobs) and possible accessibility and support measures;
- mentoring can be an excellent way of forging links between a student and the world of employment. An experienced professional makes their professional network available to a student who is seeking pathways into employment or wants to get a foot in the door;
- apprenticeships and professional training contracts are preferred routes into employment, particularly when career objectives are clearly defined. These schemes gradually merge practical activities with theoretical concepts and familiarise the student with the workplace environment. At the end of the contract, in addition to having acquired solid experience, the student benefits from a useful professional network, which can be developed within the existing workplace or elsewhere. In cases of students with autism or disabling mental health conditions, it may be necessary for the educational institution to establish robust support measures, possibly involving the services of specialised providers.

For a person with a disability, the successful transition into the workplace is a delicate process that requires great care and attention.

One common misconception held by companies is that the new employee has no prospects for professional development or progression.

Academic achievement empowers learners, gives them confidence and nurtures their ambitions. It also legitimises their chosen career objectives. Regular contact can sometimes be established with the employer's supervising teams to ensure that the new arrival is finding their feet, that their skills match the job description and that opportunities exist for acquiring new skills.

It is also recommended that the employer regularly analyses and fulfils the training needs of disabled employees. Although the battle against prejudice is far from over, things are changing where integration into employment is concerned. Advances in management, globalisation and innovation increasingly lead companies to consider "neurodiversity as a competitive advantage"[7].

There is now much greater recognition of the value that individual talent brings to collective work. Inclusion is gradually being equated with improved performance, and it benefits everyone.

7. https://hbr.org/2017/05/neurodiversity-as-a-competitive-advantage

EXPERIMENT
PROACTIVE SUPPORT TO AID INTEGRATION INTO THE WORKFORCE

In 2017 and the first semester of 2018, the Sciences Po Disability Service ran a trial providing proactive support to three students with disabilities to aid their transition into employment. Two of the students had RQTH (disabled worker) status and were having great difficulty finding employment.

The objective was to provide students with close support in the educational context in order to prepare them for autonomy in their working lives, with additional information provided before the usual career guidance.

This supplemented the career objective review session, routinely offered to students and focused on the significance of their studies. This provided an opportunity to reassure them about their aspirations and provide them with detailed advice and specific information relating to their future plans.

Initially, the range of career possibilities based on the student's aspirations was clearly defined. Next, a preparation period with a customised timescale supported the transition.

For one of the students concerned, several support measures were put in place: bimonthly discussions to work on defining the career objectives and working towards them; mock interviews with debriefings; regular discussions to answer questions about a variety of work situations; social skills coaching with an external service provider.

The primary innovation was the active support given to the search for an internship or first job in order to get through the door, followed by the subsequent work coordinated with the partner employer.

This work with the partner employer has four components:

- clearly defining the framework of the internship or job and the work it entails;
- raising the manager's awareness of the student's circumstances (with the student's consent);
- on-site training for the teams or employees that will be working with the student (inclusion and performance);
- helping the company during the internship or job in the event of difficulties integrating into the work environment.

Simultaneously, administrative support is provided to the student according to need (e.g. with the procedure for signing the internship agreement where applicable) and logistical support is offered when beginning the internship or job.

The provision of these support measures produced some interesting results. The first student monitored in this context completed an internship at a research centre, which was negotiated and organised as part of the support provided. This allowed him to experience social relations in the workplace, and to gain valuable work experience and establish a professional network.

The other two students carried out internships in Sciences Po partner companies. For each of them, the time spent in the workplace was successful and passed without any major problems, to the great satisfaction of their internship coordinators.

The three students, who were experiencing difficulties before being provided with support, regained their self-confidence and developed solid career aspirations based on the success of this experience.

PART II
INFORMATION, AWARENESS AND PRACTICAL RECOMMENDATIONS

COGNITIVE DISORDERS

In its definition of disability, the 2005-102 Disability Act makes an explicit distinction between cognitive functions on the one hand and physical, sensory, mental and psychological functions on the other, thus enabling disorders of each to be recognised as disabilities in their own right.

Cognitive disorders are defined by the alteration of one or more cognitive functions that affect day-to-day life.

Depending on their origin, they can be temporary, sustained or irreversible.

Cognitive disorders manifest in multiple and diverse ways and can combine with other disorders in that:

- they can affect one or more cognitive function;
- they may be isolated or associated with other types of disorders (psychological, physical, sensory).

In all cases, a differential diagnosis is essential to determining both the nature of the disorder (e.g. a psychological disorder that diminishes cognitive skills) and an appropriate plan for care and management of the condition.

Cognitive disorders can be congenital or acquired and can appear at any age. This differentiation has led to the use of a range of terms because the various disorders have neither the same characteristics nor require the same methods of care. Disorders beginning with 'dys', such as dyslexia, dyspraxia, and dyscalculia, refer to congenital conditions (e.g. neurodevelopmental disorders). Disorders beginning with an 'a', such as apraxia, refer to acquired disorders (e.g. those resulting from an accident or illness). The use of the term 'dyspraxia' therefore indicates that an alteration in the ability to perform physical movements is of developmental origin (presenting from early childhood onwards), while the term 'apraxia' is used when these symptoms occur as a result of
an acquired brain injury.

There are three main categories of cognitive disorders.

1) Neurodevelopmental cognitive disorders

These disorders are congenital and symptoms usually present from early childhood onwards. When the disorder is mild, or the affected child is able to compensate for the difficulties on his or her own, sometimes in a supportive environment, it may be diagnosed late or never detected.

Neurodevelopmental cognitive disorders have multiple causes. They result from a complex combination of genetic, congenital and neonatal factors (low birth weight, hypoxia at birth), neurobiological and environmental factors (diet, vulnerability).

Among the neurodevelopmental cognitive disorders, specific learning disabilities (i.e. the 'dys' disorders) and attention deficit disorder with or without hyperactivity (ADD/ADHD) are the most common. Executive function disorders are also counted among the neurodevelopmental cognitive disorders.

Due to their neurodevelopmental origin, pervasive developmental disorders (PDDs) are also included in this category, although some classifications place them in a separate field. In particular, they cover all disorders related to the autism spectrum.

2) Acquired cognitive disorders

These acquired disorders affect people of all ages and can be temporary, long-lasting or become chronic. Their appearance is most often linked to the direct or indirect effects of a major illness, a particular medical treatment or accidental brain damage.

They include, for example, aphasia, alexia, agraphia, acalculia, agnosia, apraxia, amnesia and hemispatial neglect, also called hemiagnosia (difficulty perceiving and reacting to information transmitted to one side of the body).

3) Progressive cognitive disorders in adults

Progressive cognitive disorders in adults are the consequence of illnesses that occur in adulthood and affect the central nervous system (neurodegenerative diseases, multiple sclerosis) in a progressive and irreversible way.

Cognitive disorders are very diverse and the ways they manifest can vary according to their severity, the degree to which they are cumulative and their association with other conditions. Thus, it is difficult to make generalisations about individuals' experiences of a condition, as each situation has many different contributing factors.

The difficulties and needs of the people affected are therefore assessed according to their environment, the care and support they receive and their individual profile (medical history, other individual details, personality).

Often poorly understood and underestimated in terms of their effects, cognitive disorders can nevertheless have disabling consequences on the everyday lives of those affected, and a major impact on their self-esteem.

Progress in screening and improvements in care and support have led to a significant increase in the number of students being identified with cognitive disorders. Despite this, those affected are still often treated with great indifference and/or misunderstanding. This is largely explained by the relative lack of knowledge about these conditions (both their symptoms and consequences), common misrepresentations, and the relative invisibility of these disorders beyond their evident impact on learning.

Cognitive disorders have a direct impact on educational paths because they affect the core processes involved in learning. Some academic difficulties that may appear to be explained by gaps in knowledge, lack of effort, unwillingness, or limited intellectual abilities may actually hide complex and painful situations related to undiagnosed or undeclared cognitive disability.

DEFINITION
COGNITIVE FUNCTIONS

Cognitive functions cover all of the mental processes involved in receiving, processing and communicating information. They are therefore the basic mechanisms of interaction between individuals and their environment, and they are fundamental in learning. They have an effect on a multitude of actions and moods, the ability to experience and express emotions, to act, and the speed with which actions are carried out.

Cognitive functions directly concern:

- executive functions (i.e. all the organisation, planning, evaluation and inhibitive functions that enable actions to be adapted to a context);
- reasoning, abstraction;
- attention and concentration;
- memory;
- language (spoken and written);
- visuospatial abilities (orientation, representation of self and objects in space, processing of spatial data);
- agnosia (the inability to process sensory information);
- performance of movement.

EXAMPLES OF SPECIFIC LEARNING DISABILITIES
THAT ARE STILL POORLY UNDERSTOOD IN HIGHER EDUCATION

Dysphasia

Dysphasia is a specific spoken language development disorder that disrupts expression and/or comprehension.

Dysphasia covers a broad range of situations. It can be receptive (comprehension difficulties), expressive (spoken expression difficulties) or both.

Because it impairs spoken communication functions, dysphasia can have significant effects on all aspects of social life, particularly in an educational setting where it complicates learning, with consequences that may be compounded by other disabilities.

The persistence of symptoms in adulthood depends on their initial severity and their management during development.

Difficulty in expressing oneself can lead to withdrawal, isolation or even aggressiveness.

Dysphasic students are particularly penalised by oral exercises such as presentations (slowness of expression, the impression that the words don't come out, hesitation, signs of visible difficulty when speaking, etc.).

Dyscalculia

Dyscalculia is a disorder relating to mathematical abilities and the perception of numerical quantities, which results in difficulties in calculating, counting and reading/writing numbers.

AN EXAMPLE OF A LITTLE-KNOWN DISABLING COGNITIVE DISORDER: EXECUTIVE FUNCTION DISORDER

The executive functions can be described as the 'orchestra conductor' of the brain.

They cover all the complex brain processes involved in non-routine activities (adapting one's actions to a new context). They are used to initiate, plan, carry out and complete tasks.

When an executive function disorder is neurodevelopmental in origin, it is linked to dysfunction of the prefrontal cortex.

It is often associated with working memory disorders (i.e. the short-term memory that stores and processes the complex data required to perform a task). One example would be remembering all the words in a sentence in order to understand its meaning as a whole.

In an educational context, executive function disorders have multiple consequences:

- **difficulty adapting intellectual strategies** to a specific exercise;
- **difficulty changing strategies in the event of failure** (persisting with the error)**;**
- **difficulty adapting behaviour to a given context;**
- **difficulty controlling emotions;**
- **difficulty initiating,** planning and organising an activity;
- **impulsiveness.**

Executive function disorder causes significant academic problems, limiting the range of possibilities in terms of future paths after university. It generates tremendous fatigue because the act of carrying out the regular tasks and demands of daily life requires a great deal of effort (listening, understanding instructions, self-control, taking notes, responding to issues, etc.).

DUAL-TASK WORK: A MAJOR PROBLEM

When learning a common task involving both mental and motor skills, a high level of concentration is required.

Through the process of repetition, performing the task becomes automated and no longer requires sustained attention. Thus the task is then stored in procedural memory and, if necessary, is retrieved instantly and subconsciously. This is the way in which all everyday tasks are learnt.

Automated control over habitual actions (procedural learning) thus makes it possible to focus attention on what is not routine.

When a task that should normally be automated is not properly automated, it requires concentration, thus reducing the availability of the necessary attention to perform other tasks simultaneously.

In the university context, when the processes of reading, writing and/or spelling have not been automated, a student is often in a dual task situation and forced to divide attention between non-automated habitual tasks that still require concentration and other tasks such as analysing, understanding and reasoning.

This is the case for students with a specific learning disability in many educational settings (reading and simultaneous comprehension, active listening and note-taking, etc.).

DYSLEXIA

SOME USEFUL GUIDELINES / TIPS

Dyslexia is a specific disorder of written language acquisition that results in learning and reading difficulties. It is the most common specific developmental cognitive disorder.

Difficulties related to dyslexia appear from the earliest stages of learning. It is recognised that 3% to 5% of children are affected[8].

Dyslexia is of neurological origin. It is not caused by a psychiatric or sensory processing disorder. It is not an expression of intellectual difficulties.

One hypothesis is that it results from a disruption in neuronal migration during brain formation, hindering brain connectivity in the areas used for reading. The causes of this neurological anomaly are a complex combination of genetic and environmental factors.

The evolution and persistence of symptoms in adulthood depends on multiple factors:

- the severity of the initial dysfunctions;
- the socio-educational environment;
- the level and quality of the care and support received;
- the association/combination or not with other disorders;
- the psychological profile of the person.

The early diagnosis of dyslexia, and the correlative medical, allied health professional (speech therapy) and educational responses that can be provided are important elements in limiting its educational and social consequences.

In general, dyslexia is characterised by impaired development of the process by which reading becomes automatic. Words are recognised and memorised with difficulty or imperfectly, and must therefore be systematically deciphered, requiring significant cognitive effort.

Three types of dyslexia are distinguished according to the nature of the disorders considered.

Phonological dyslexia is extreme difficulty reading as a result of phonological impairment, or the ability to manipulate the basic sounds of language. The individual sounds of language (graphemes and their corresponding phonemes) become 'sticky', and the reader cannot break them apart or manipulate them easily. This preliminary stage of learning how to read, called the 'alphabetical stage', is crucial for the subsequent successful acquisition of written language.

Surface dyslexia refers to difficulties in memorising and recognising words in their different forms. Lexical changes related to the application of grammar rules (e.g. verb agreements) are poorly identified and can lead to misunderstanding.

Combined dyslexia combines the disorders of both types.

Dyslexia complicates the acquisition of written expression and has direct negative effects on the application of the rules and conventions of writing. Consequently, in most cases dyslexia leads to associated spelling disorders (dysorthographia). These difficulties are all the more significant and persistent when dyslexia is accompanied by other specific learning disorders, such as dyspraxia or attention deficit disorder with or without hyperactivity.

8. https://www.inserm.fr/information-en-sante/dossiers-information/troubles-apprentissages

Students with dyslexia, through their acquired experience and the support they receive, often learn to cope with their disability. Through repetition and habit, many of them have developed individual strategies to overcome obstacles.

Nevertheless, this does not make the educational journey of most students with dyslexia any less complicated as they are forced to make significant daily efforts to perform each of the tasks involved in reading and/or writing.

Indeed, depending on the severity and persistence of their disorder, at the usual age of entering higher education, dyslexia can still lead to:

- **laborious or hesitant reading;**
- **slow written comprehension;**
- **not very fluid writing;**
- **written expression with many spelling mistakes that are surprising from a phonetic point of view;**
- **clumsy syntax;**
- **greater tiredness.**

Depending on the degree of difficulty experienced, students with dyslexia are often placed in a dual-task work situation.

In terms of research, advances in medical imaging (some highly publicised) have improved the understanding of dyslexia and have opened up interesting avenues for its treatment/management.

STUDENT TESTIMONY

"English classes are always a pain in the ass, but the worst part is the thematic courses that are in English. I had one this year. It's simple, but most of the time I didn't even know what they were talking about. I had to go over all the sessions as if I was starting from scratch. People don't realise how awful it is not to understand anything and to feel like an idiot."

[Student, April 2016]

These advances raise hopes for finding ways to effectively overcome the condition in the medium term, although many aspects remain to be explored. Nevertheless, the advances contribute to the emergence of new knowledge and therefore new practices that benefit the learning experience for individuals with dyslexia.

AWARENESS AND ISSUES TO WATCH OUT FOR

Students with dyslexia may benefit from extra time during written assessments or exams to put together responses. However, this compensatory measure does not resolve accessibility problems in everyday learning.

Depending on the individual case, dyslexic students may have a number of traits that complicate their learning:

- **written comprehension is slow and requires several readings;**
- **dyslexic students are often very anxious about what is expected of them academically and are apprehensive about classroom situations.** The difficulty of dual-task work (reading course material or listening and understanding, with note-taking) requires a constant mental juggling act, which is a major source of stress;
- **the increased effort required for learning activities causes significant fatigue.** The strain of dual-task work results in substantial investment of time and energy outside the classroom. Making up for missing grades and/or understanding what has been said often requires the additional use of textbooks. This is all the more marked when concentration problems are added;
- **the difficulties encountered are particularly acute in language learning, and particularly with English, which is one of the most challenging languages for students with dyslexia to learn.**

GUIDELINES AND RECOMMENDATIONS

- Distribute the student workload evenly.
- **Communicate work instructions using different methods: orally (captive attention) and in writing, to avoid note-taking.**
- **Provide course materials or documents before the appropriate session to reduce apprehension about the learning situation and minimise dual-task work.**
- Indicate the texts to be read for a session with reasonable deadlines.
- Provide specific bibliographic recommendations, bearing in mind that they may be useful for catching up on parts of the course that are poorly understood or where notes were not taken.
- Consider errors or mistakes made when returning written assignments but do not sanction them excessively to avoid discouraging the student. It may be advisable for the student to contact the Disability Support Service to acquire spelling correction software.
- Promote the use of text-to-speech software.
- **Adapt reading materials and course documents to make them more accessible (see Part I).**
- **Implement explicit learning methodologies (clear guidelines, concrete illustrations, examples of answers, etc.).** With respect to this, it is essential to explain the reason for a grade, good or bad, by highlighting the aspects acquired as well as the progress to be made to guide future efforts. This will help avoid discouragement arising from a poor understanding of the knowledge gaps to be addressed.

STUDENT TESTIMONY

"In general, when I have to read a text,I need to read it three times to understand it and get something out of it. The first reading is for deciphering the text, I'm not reading in the full sense of the word. I look at how the text is constructed, I locate the different parts and I try to identify the important passages or words. The second reading is to decode. I try to understand the meaning of the text, the main ideas. I read the introduction and conclusion carefully, for example. The third reading is to understand in detail, step by step."

[Student with dyslexia, April 2016]

KEEP IN MIND

- **Dyslexia is a neurodevelopmental disorder affecting the acquisition of written language and is not caused by a deficiency in intellectual ability.**
- **Dyslexia causes significant difficulties in writing and/or reading, with delayed associated comprehension.**
- **Dyslexia leads to significant cognitive fatigue, particularly in dual-task work situations (high attention costs, mental juggling act) and high levels of anxiety about academic expectations.**
- **Good accessibility of course materials and reading materials can ameliorate learning difficulties.**
- **The provision of course materials before sessions and the granting of reasonable time for tasks involving reading are recommended.**

People with dyslexia often have a strong capacity for work (habit of compensating for their difficulties, perseverance) and resourcefulness (habit of developing strategies to overcome their difficulties).

DYSPRAXIA

SOME USEFUL GUIDELINES / TIPS

Dyspraxia (developmental coordination disorder) is a specific development disorder affecting the learning of motor coordination. It is often associated with visuospatial or visuomotor disorders.

It results in disturbances in the execution and automation of learned actions, even though the physical faculties necessary for their realisation are not impaired.

Actions acquired through learning depend on several cognitive faculties: motor synchronisation, the processing of visual information and representation in space, the ability to perform corresponding movements and the processes of implementing goal-oriented action. These include writing (graphic gesture) and the use of educational tools (ruler, compass, etc.).

The control and coordination of acquired gestures is not automated. They become difficult to perform, awkward and even hesitant, requiring significant concentration and cognitive investment.

Dyspraxia is a neurodevelopmental condition and is not caused by any intellectual, sensory, motor or psychiatric disability. It mainly affects boys and results from abnormalities in the parietal lobe of the brain. It is caused by a complex combination of genetic and environmental factors. It impacts motor functioning by altering faculties used for executing and coordinating gestures. It does not concern implicitly learned actions (sitting, lying down, walking, etc.).

The evolution and extent of symptom persistence in adulthood depends on a multitude of factors:

- severity of the initial dysfunction;
- socio-educational environment;
- level and quality of the care and support provided;
- comorbidity or not with other disorders;
- the psychological profile of the person.

The early diagnosis of dyspraxia, and the correlative medical, allied health professional (psychomotility) and educational responses that can be provided are all important elements in limiting its educational and social consequences.

In general, dyspraxia is characterised by impaired development in learning and coordinating acquired actions. It is also frequently accompanied by other disorders, either in an associated way in the field of learning (dyslexia, dyscalculia, ADD/ADHD) or because of its negative effects on emotional and social life (depression, etc.).

Beyond the specificity of each individual situation, dyspraxic disorders can be grouped into several types according to their nature.

Constructional dyspraxia:

- difficulty coordinating fine movements;
- difficulty understanding spatial relationships;
- spatial organisation problems;
- reading and counting problems;
- difficulty assessing distances;
- difficulty drawing or assembling objects.

Non-constructional dyspraxia:

- difficulties in performing gestures or correctly sequenced movements.

This second category often distinguishes between:

- Ideational Dyspraxia: difficulty using objects (writing with a pencil, using a key, etc.); difficulty dressing and putting on shoes;
- Ideomotor Dyspraxia: particular difficulty imitating symbolic gestures (those that have a cognitive or social sense) such as waving hello or pretending to brush one's hair;
- Developmental Verbal Dyspraxia or Oromotor dyspraxia:
  - difficulty in articulating speech;
  - lack of verbal fluency;
  - difficulty making gestures involving the mouth (whistling, blowing candles).

Students with dyspraxia, through their acquired experience and the support they may receive, often learn to cope with their disability. Through repetition and habit, many have developed individual strategies to overcome the obstacles.

Nevertheless, this does not make the educational journey of most students with dyspraxia less complicated as they are forced to make significant daily efforts to perform acquired actions.

Indeed, depending on the severity of the disorder, on entering higher education dyspraxia can still lead to:

- **slow, hesitant and poorly formed handwriting (dysgraphia);**
- **problems understanding and analysing tables, graphs or maps (visuospatial disorders);**
- **laborious oral expression (in the case of verbal dyspraxia);**
- **laborious or hesitant reading (visuospatial difficulties);**
- **difficulty with orientation and finding a location;**
- **difficulty organising and planning, including ideas.**

Depending on the intensity of the difficulty experienced, students with dyspraxia are often placed in a dual-task work situation.

AWARENESS AND ISSUES TO WATCH OUT FOR

Dyspraxic students may benefit from extra time during written assessments and exams to put together responses. However, this compensatory measure does not resolve accessibility problems in everyday learning. Indeed, depending on the individual case, dyspraxic students may have a number of traits that complicate their learning:

- **note-taking is laborious and slow;**
- **understanding and analysing tables, graphics and maps is difficult;**
- **written comprehension can be difficult, especially if content and layout is dense;**

DYSGRAPHIA (DIFFICULTY ASSOCIATED WITH DYSPRAXIA)

Dysgraphia is a persistent functional disorder that disrupts the learning and performance of writing. The act of writing, which amounts to 'drawing letters', can be painful to perform. It is slow, costly in terms of concentration (to the detriment of other aspects) and degrading (the writing is often difficult to read and untidy).

Dysgraphia can be caused by dyspraxia (difficulty in forming letters), ADD/ADHD (impulsiveness having an impact on the quality of writing) or dyslexia-dysorthographia (when writing speed is slowed).

At university, this disability can easily be compensated for by the use of a computer, effectively combined with being allowed extra time to put together responses in exams.

- **written work is poorly presented (difficulty organising the available space);**
- **the handwriting lacks readability and/or care;**
- **these students are often anxious about what is expected of them academically and are apprehensive of classroom situations.** The difficulty of dual-task work (reading course material or listening and understanding, with note-taking) requires a constant mental juggling act, which is a major source of stress;
- **the increased effort required for learning activities causes significant fatigue.** The difficulty of dual-task work results in a substantial investment of time and energy outside the classroom. Making up for missing grades and/or understanding what has been said often requires the additional use of textbooks. This is all the more marked when concentration problems are added.

GUIDELINES AND RECOMMENDATIONS

- Ensure that the course locations are clearly signposted.
- Recommend the use of a guidance or geolocation application to facilitate navigation.
- Distribute the student workload evenly.
- **Authorise the use of computers in class, as well as the return of typed written assignments.**
- **Communicate work instructions using different methods: orally (captive attention) and in writing, to avoid note-taking.**
- **Provide course materials or documents before the appropriate session to reduce apprehension about the learning situation and minimise dual-task work.**
- Indicate the texts to be read for a session with reasonable deadlines.
- Provide specific bibliographic recommendations, bearing in mind that they may be useful to the student for catching up on parts of the course that he or she has poorly understood or where notes were not taken.
- Consider errors or mistakes made when returning written assignments but do not sanction them excessively to avoid discouraging the student. The same approach should be applied to clumsiness of form, the quality of writing and the overall presentation.
- **Give students with significant speech difficulties the choice of doing written work, rather than making a presentation, or allow them to use presentation tools that reduce the pressure of speaking.**
- Encourage the use of text-to-speech and speech-to-text (voice recognition) software.
- **Adapt reading materials and course documents to make them more accessible (see Part I).**
- **Implement explicit learning methodologies (clear guidelines, concrete illustrations, examples of answers, etc.).** With respect to this, it is essential to explain the reason for a grade, good or bad, by highlighting the aspects acquired as well as the progress to be made to guide future efforts. This will help avoid discouragement arising from a poor understanding of the knowledge gaps to be addressed.

STUDENT TESTIMONY

"I often go to class with fear in my stomach, and I don't sleep well when I have homework to do or if I have to make a presentation. It's even worse before the exams. Sometimes I end up in tears because it's so hard. Yet, in other situations, when I'm with my family and friends, I'm not particularly stressed. With my problems, classes are an ordeal. Everything is complicated for me. At weekends I spend hours reading the texts that we're asked to read in advance because it takes too much time during the week. I'm so tired in the evening that I can't work. As a result, I have to organise myself to do everything else during the day between classes.

I'm used to it now, and for exam revision I manage as best I can, even if there are still parts of the course that I'm not so familiar with. It's complicated for me to listen, to remember explanations and take notes with the computer because I write too slowly. I amass all the information from the classes in different ways, so in the end, I have everything the teacher says. Depending on how tired I am, there are a lot of things I don't understand. I have to go over all the sessions and I struggle compared with the others. I think that's the worst. In fact, I have to make a huge effort to just keep up. I feel really useless, especially on days when I have several classes in a row.

I am quickly exhausted, and there is often a point in the day when I can no longer do anything. I can't concentrate at all. I just want to go home and get some sleep and wish people would stop talking to me."

Illustrations of several incidences of the disorder: anxiety; severe fatigue; dual-task (difficulty listening and taking notes); slow written comprehension (difficulty reading).

[Student with dyspraxia, November 2017]

KEEP IN MIND

- **Dyspraxia is a neurodevelopmental cognitive disorder affecting the automated execution of learned actions and is in no way caused by a deficiency in intellectual ability.**
- **Dyspraxia causes significant difficulties in reading, writing, slow comprehension, difficulties in assessing spatial relationships and problems with drawing or assembling objects.**
- **Dyspraxia leads to significant cognitive fatigue, particularly in dual-task work situations (high attention costs, mental juggling act) and, consequently, to high anxiety about what is expected academically.**
- **Easily accessible course materials and reading materials can ameliorate learning difficulties.**
- **Providing course materials before sessions and allowing reasonable time for reading tasks are recommended.**

People with dyspraxia often have a strong capacity for work (perseverance, habit of compensating for their difficulties) and resourcefulness (habit of developing strategies to overcome their difficulties) and good computer skills.

ATTENTION DEFICIT DISORDER WITH OR WITHOUT HYPERACTIVITY (ADD/ADHD)

SOME USEFUL GUIDELINES

Like specific learning disabilities, attention deficit disorder with or without hyperactivity (ADD/ADHD) is a neurodevelopmental disorder. It is therefore in no way the symptom of an intellectual disability, disabling mental health condition or emotional problems. It can neither be linked to educational deficiencies nor an absence of parental authority in early childhood, as is often thought to be the case.

Like all neurodevelopmental disorders, the causes of ADD/ADHD are a complex combination of genetic, congenital, neurobiological and environmental factors.

Advances in neuroscience have now made it possible to identify the causes of the disorder. It is predominantly the result of a developmental delay in the prefrontal cortex, a region of the brain involved in the core learning processes (attention, impulse inhibition, planning, regulating emotions).

There is also a biochemical factor, namely a disruption of two important neurotransmitters, dopamine and norepinephrine.

Three related characteristics can normally be observed in the case of ADHD:

- inattentiveness;
- impulsiveness;
- hyperactivity.

Problems with being able to control attentiveness are common to all people affected by the disorder to varying degrees. This presents as difficulties remaining attentive over a continuous period of time (varies from case to case) and difficulties focusing attention on a task. **It is also characterised by distraction, both by one's own thoughts and by all forms of external stimulation (noise, movement, etc.).**

As a result, attention spans are short. Sustained concentration on a task or object is difficult and requires considerable cognitive effort that takes a heavy toll and leads to rapid fatigue. Yet, people with ADHD sometimes demonstrate a remarkable ability to focus and display intellectual hyperagility over short periods of time.

They can remain focused on subjects that interest them, but over shorter than average periods of time and preferably at the last minute, which can cause stress and lead their attention to wander. Consequently, they work more like a sprinter than a long-distance runner. However, excessive stress and anxiety tend to increase attention management difficulties.

Impulsiveness is not a universal symptom in people affected by the disorder, but it is common, and usually differs depending on characteristics and age. Behaviours include include excessive talking, impatience, excessive spontaneity (words and gestures), errors caused by constant rushing (doing things without thinking) and a low tolerance for frustration.

Hyperactivity results in physical agitation or an irrepressible need to move. This is often the symptom of the disorder that first leads to diagnosis. However, in many cases it is not present or significant. This is why attention deficit disorder is referred to as being with or without hyperactivity. People who always appear to be distracted and/or are considered to be dreamers may therefore have ADHD.

In France, ADD/ADHD affects around 5% of primary school children (4% to 8% depending on the study) and persists into adulthood in just over half of cases, with symptoms that vary in severity[9].

The evolution and extent of the disorders depend on a multitude of factors:

- the severity of the condition;
- the socio-educational environment;
- the level and quality of care and support;
- association or not with other disorders;
- the psychological profile of the person.

The prevalence of ADD/ADHD is significantly higher in the male population than in the female population, in terms of what is now clinically counted. However, according to many specialists this could be due to under-diagnosis of girls, as they often display fewer signs of hyperactivity.

The early diagnosis of ADD/ADHD makes it possible to provide medical responses, particularly psycho-pedagogical treatment, which are decisive factors in limiting its consequences in the long term. It is estimated that children with ADD/ADHD are three times more likely to fail at school than others. Almost half of them will have significant learning difficulties strongly correlated with being undiagnosed.

Students with ADD/ADHD often learn to cope with their disability or to better manage its effects, especially if they receive appropriate support at an earlier age. In addition to the reduction of symptoms with age, many students are able to develop their own strategies to either compensate for or overcome obstacles.

However, this does not necessarily make the educational journey of the students concerned less complicated because they still have to make significant efforts to achieve what is expected of them academically, regardless of their level or ability.

9. http://www2.cnrs.fr/presse/communique/3507.htm

WHAT DO ATTENTIONAL ABILITIES ENTAIL?

Attention, which is the ability to concentrate in order to perform a task correctly, is the product of complex neurological processes, particularly in relation to the inhibition function (blocking or activating automatisms; blocking or activating certain functions necessary to perform other functions). These neurological processes filter the sources of stimulation and keep attention focused on the task.

In daily life, several types of attention methods allow a wide range of tasks to be performed in various configurations:

- sustained attention (e.g. reading a book without disengaging);
- divided attention (e.g. having a conversation on the phone while driving);
- selective attention (e.g. correcting students' homework in a noisy place).

People with ADD/ADHD have difficulty adjusting their attention in these different ways.

Depending on the severity of their experience of ADD/ADHD at the age of entering higher education, students can experience:

- **significant attention difficulties;**
- **organisational difficulty;**
- **difficulty implementing tasks;**
- **difficulty in meeting certain constraints (schedules, deadlines, expectations, etc.);**
- **difficulty in meeting deadlines for laborious tasks, particularly administrative ones;**
- **random time management;**
- **significant anxiety;**
- **feeling overwhelmed and a desire to withdraw when faced with expectations.**

To varying degrees, students with ADD/ADHD often find dual-task work difficult, especially at times of severe cognitive fatigue.

ADD/ADHD is frequently associated with other specific learning disabilities and autism spectrum disorders. Similarly, association with psychiatric conditions (mood disorders, anxiety disorders, oppositional defiant disorder, behaviour disorders) is very common and a major factor in predicting the course of the medical condition

AWARENESS AND ISSUES TO WATCH OUT FOR

Students with ADD/ADHD may benefit from extra time during written assessments and exams to put together responses. Organising a break during exams and allowing students to stretch can be useful. For easily distracted students, taking the tests in a separate room may be a possible solution.

The relevance of these support measures should, however, be assessed on a case-by-case basis. For example, granting extra time may not suit impulsive or hyperactive students who often prefer to leave before the end of tests because of the difficulty they experience remaining in place.

Students with ADD/ADHD are also often granted deadline extensions for submitting coursework.

While useful, such compensatory measures only offer limited help in mitigating the recurring difficulties that these students may encounter.

Although every individual case differs, students with ADD/ADHD are likely to have a number of symptoms that complicate their education:

- **they are prone to forgetting important or seemingly obvious things;**
- **they frequently have difficulty regulating their emotions;**
- they often have very uneven academic results, depending on the level of attention they have managed to invest;
- **they are often very anxious about academic expectations and dread classroom situations.** For those with low capacities for divided attention (listening and understanding, taking notes), the constant mental juggling act required is stressful;
- **the increased effort required for learning activities makes them extremely tired;**
- **they regularly have difficulty starting or finishing assignments (implementation), which has an impact on deadlines;**
- **they experience difficulties in planning and organising their work.**

The impact of attention deficit results in a significant investment outside the classroom. Making up for missing grades and/or understanding what has been said often requires the additional use of textbooks or internet resources.

GUIDELINES AND RECOMMENDATIONS

- Distribute the student workload evenly.
- Be tolerant with certain hyperactive attitudes (fidgeting, leg agitation, playing with a pen or other object, etc.).
- Allow a discreet 'time out' moment during class to help students with ADD/ADHD regain attention.
- Allow students with ADD/ADHD to sit in the front row, so that they are less easily distracted.
- **Communicate work instructions using different methods: orally (captive attention) and in writing, to avoid note-taking.**
- **Provide course materials or documents before the appropriate session to reduce apprehension about the learning situation.**
- Provide specific bibliographic recommendations, bearing in mind that they may be useful to students for catching up on parts of the course that they have poorly understood or where notes were not taken.
- **Provide encouragement and support to students with ADD/ADHD. It is important to minimise the potential consequences of missing assignment deadlines.**
- Enable students with ADD/ADHD to work on topics (presentations, assignments) that enhance or motivate them (positive dynamics).

STUDENT TESTIMONY

"It's depressing to say, but I can never stay focused throughout an entire class. After a while, I completely zone out. I can't even listen any more, let alone take notes. I wait for it to pass, trying as best I can to capture two or three words in passing. In between, I think of something else, sometimes I doodle or go on the internet if I've got my computer with me. That's if I'm not too tired and the subject interests me.

Otherwise, I have difficulty getting into the class from the very beginning. I listen at times, depending on whether something catchesmy attention. As a result, I only remember snippets of classes. Most of the time, it's by rereading the notes I get hold of that I find parts I vaguely remember. It's quite frustrating because I get bored a lot in class, even if I try to take part and be motivated.I feel like I'm skimming over everything, but I can't help it, I can't force myself to concentrate."

[Student with ADHD, February 2018].

KEEP IN MIND

- **ADD/ADHD is a neurodevelopmental cognitive disorder, not an expression of an intellectual disability.**
- **ADD/ADHD affects attentiveness, to a greater or lesser degree, in unsystematic association with high impulsiveness and/or hyperactivity.**
- **ADD/ADHD causes significant cognitive fatigue and resultant high levels of anxiety about academic expectations. It also leads to difficulties when implementing tasks and organising work.**
- **Communicate work instructions using different methods: orally (captive attention) and in writing to avoid note-taking.**
- **Provide course materials or documents before the appropriate session and allow reasonable time to carry out tasks.**

HIGH FUNCTIONING AUTISM

SOME USEFUL GUIDELINES

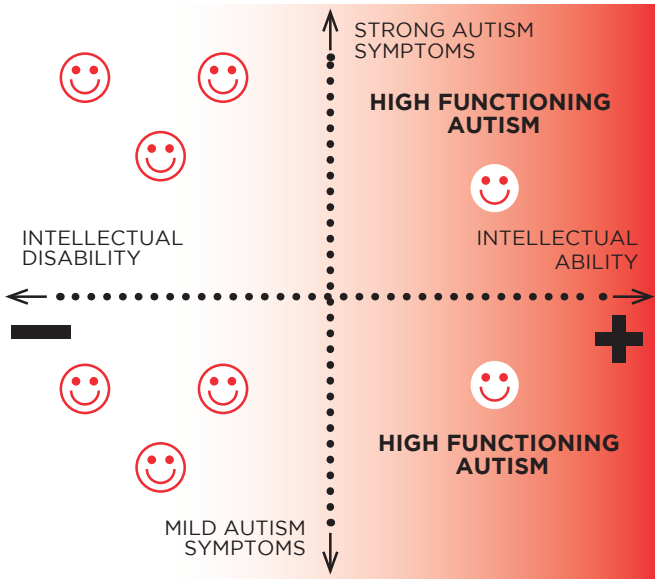
Commonly referred to as autism, autism spectrum disorder (ASD) covers a variety of conditions. These include autistic disorder, Asperger syndrome, childhood disintegrative disorder (CDD) and pervasive developmental disorder not otherwise specified (PDD-NOS).

People with ASD share traits in three social and cognitive areas: relationships with others, communication patterns and altered functioning of certain behaviours.

While the different forms of ASD are each categorised according to their own clinical profiles, the symptoms vary and manifest in specific ways according to the individuals concerned. The age at which symptoms appear, their severity, the combination in which they occur and their patterns of association with each other and with other possible symptoms are among the main factors influencing the profile of each person with autism. The notion of a spectrum also makes it possible to reflect the great diversity of situations involving ASD.

Autism spectrum disorders are generally associated with neurobiological disorders in the development and functioning of several regions of the brain, including those responsible for the processes of communication, planning, expression and understanding, as well as emotional processes. They occur from early childhood and remain structural. In autism the sensory functions are also affected, affecting an individual's relationship with the external environment to varying degrees. For example, hypersensitivity to sound and light can cause extreme discomfort, with the result that noisy and lively places are avoided.

Around 1% of the general population is affected by ASD, with more males diagnosed than females.



Recent studies have shown that genetic factors may play a role in the development of ASD. Syndrome form is defined as when the genetic cause is clearly established; this corresponds to about 10% of cases. However, one thing is now certain: **autism spectrum disorders do not have psychological or psychiatric causes, as was long believed.** They were considered to be influenced by a dysfunctional mother-child relationship before advances in brain imaging and genetic research invalidated this hypothesis.

One important distinction can be made within the autism spectrum, notwithstanding the individual profiles of people with ASD. It concerns on the one hand individuals living with sometimes severe associated intellectual disabilities, and on the other hand those who are identified under the generic term 'high-functioning autism'. In most cases, the latter manage to lead an autonomous daily life with varying degrees of difficulty.

ASDs are long-term disorders but the impact of symptoms is progressive. ASDs generally improve with age, through experience (compensatory learning), the provision of appropriate support and, in some cases, the right care (cognitive and behavioural therapies). The everyday environment (professional and personal surroundings), family and friends are crucial to the development of people with autism, as well for as their social and professional inclusion.

Asperger syndrome is the most well-known but not the most common form of high-functioning autism. It is commonly associated with people who have much higher than average intellectual potential, although they actually represent just under 20% of cases. Due to its complexity, Asperger syndrome has only recently received recognition on a clinical level.

ANTICIPATE THE UNEXPECTED

People with autism are resistant to change, the unexpected and anything that disrupts their routines. They are quickly unsettled by an unknown situation for which they do not have an internalised coping mechanism.

To limit anxiety-inducing situations **it is useful to anticipate the unexpected.**

It's a good idea to write a handbook for students with autism in conjunction with their teachers, outlining detailed and explicit hypothetical situations and solutions to help them navigate everyday life at university.

Examples:

- What should I do if my teacher is late?
- What should I do if a class is postponed?
- What should I do if I am ill and cannot attend a class?
- What should I do if the fire alarm goes off during a class?
- What should I do if another student feels unwell during a class?

Compared to other forms of autism, high functioning autism or Asperger syndrome is characterised by considerable social difficulties.

Advances in research led it to be included in the World Health Organization (ICD-10)[10] and American Psychiatric Association (DSM)[11] classifications, before it was withdrawn from the latest edition along with other specific disorders. Given the individual nature of many diagnoses, which results from the substantial scope within each of the categories, American psychiatry has now adopted a classification based more on a dimensional approach with a notion of spectrum and severity that both limits categorisation and fails to reflect the diversity of clinical situations.

Nevertheless, the use of the name 'Asperger syndrome' remains deeply rooted and defended because it responds to distinctive positive social expectations beyond the specific medical criteria associated with it. In reality, the name 'Asperger syndrome' does not go far enough to convey the diversity of profiles and situations associated with it.

Recent research has highlighted the fact that many women with the typical symptoms of Asperger syndrome remain under-diagnosed or are diagnosed later compared to men.

AWARENESS AND ISSUES TO WATCH OUT FOR

High functioning autism covers a very wide variety of symptoms that can be observed in varying degrees. Their common characteristic is that of difficulty interacting with the external environment. This results from uncoordinated or limited processing of sensory information that normally requires logically anticipated actions/reactions.

To a varying extent and depending on the case, people with high functioning autism do not spontaneously interpret social expectations or the intentions, attitudes and emotions (joy, sadness, anger, annoyance, etc.) of the people with whom they communicate.

Anything that is not explicit or non-routine is indecipherable. Similarly, they cannot interpret the everyday invisible codes and rules that enable people to intuitively cope with different social settings.

10. International Statistical Classification of Diseases and Related Health Problems (ICD-10), 1993 and updated annually.
11. http://www.who.int/classifications/icd/icd10updates/en/ DSM-5, Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, Paris, Elsevier Masson, 2015.

Identifying and responding to social conventions must be learned by internalising anchored, often self-developed, reference points. This learning is more efficient in the event of an early diagnosis.

It is difficult to describe the concrete signs of high functioning autism. It is impossible to describe a standard profile as traits vary greatly according to the individual.

The most common characteristics can be listed, but it should be kept in mind that they are found in different combinations and in varying degrees according to people's background and personality:

- relative indifference to collective interactions, social isolation, withdrawal, evasive behaviour, silence;
- ability to concentrate for long periods of time on a particular element of interest, to the detriment of increased and reactive attention;
- obsessive and invasive interest in subjects of preference, sometimes unusual (rare language, type of animals, ancient historical period, etc.);
- excessive attention to detail (poor central coherence);
- becoming unsettled in the face of unforeseen situations and changes in routines;
- strong attraction for repetitive activities and structured settings;
- the creation of individual reference systems to facilitate localisation and spatial reference points (renaming strategic locations with a personalised coding system, etc.);
- inability to understand figurative expressions, ('the cat's got your tongue', 'being as rich as Croesus', 'having a frog in your throat', etc.);
- scrupulous respect for rules and deadlines, hyper-observance of instructions;
- extreme sensitivity to noise, invasive sounds, brightness;
- reluctance to make physical contact in everyday life;
- awkward behaviour (avoiding eye contact, random rules of conduct and politeness, etc.);
- difficulties in adjusting the tone and volume of the voice, quirky clothing style;
- inappropriate body language, unusual gait, strange gestures;
- rituals, stereotypical actions, automatisms;
- propensity to express ideas out of context (idiosyncrasy);
- lacking emotional expression in relation to a situation;
- difficulties in starting and ending a conversation, verbal tics;
- proven affinity for mathematics, and in general for activities that do not require subjective interpretations or choices, even if the way in which the correct results are achieved is unusual and hard to explain.

EXAMPLES OF THINGS THAT ARE EASY TO IMPLEMENT FOR A CLEAR DOCUMENT

- Visually space out a document to avoid information overload.
- Use a generously spaced and highly structured layout.
- Number everything (document pages, related course session, sections, questions, subitems) with a clear classification.
- Ensure that a logical progression is maintained in the different parts of the document.
- Explain all acronyms, even when they seem obvious.
- Add a glossary where possible.
- Reiterate a definition when it should be drawn upon to respond to a question.
- Indicate each reference to a text, table, quotation etc., so that they can be identified.
- Avoid sentences with several intuitively related ideas.
- Check that the formulations used do not include allusions or insinuations to be interpreted ('why' rather than 'how', etc.).

The consequences associated with all these characteristics put students with autism at a disadvantage. Their cumulative effect in the university environment can lead to great distress. It is important to be vigilant for signs of withdrawal, unhappiness or changes in the behaviour of the students concerned both in and out of the classroom. . In particular, students with autism may be victims of harassment or discriminatory comments. Because of genuine social naivety, they can also be easily preyed upon by malicious people. If necessary, a rapid alert to the university authorities or the Disability Support Service can facilitate an appropriate response and reduce the risk of the student dropping out.

GUIDELINES AND RECOMMENDATIONS

Although students with high functioning autism don't have any intellectual impairment, they do face significant difficulties in understanding and evaluating information.

A number of provisions can offer varying levels of support for these difficulties.

In classroom interactions

- **Allow autistic students, who are often highly sensitive to sound, to wear a noise reduction headset if they so wish, to filter out invasive noise.** This facilitates their concentration and makes it easier to remain attentive to important information.
- **If the level of natural light is sufficient, turn off or reduce light sources that cause unnecessary discomfort.**
- **Allow students with autism to choose their regular place in class and discreetly ensure that this is respected by other students.**
- **Do not insist that students with autism participate orally if they don't want to do so.**
- Be tactful and subtle (thanking them for their intervention) if you need to interrupt autistic students, who are not always able to measure their share of speaking time.

In the methods for transmitting knowledge

- **Wherever possible, make clear, definite statements and be explicit in the way knowledge is given (contextualise each statement, avoid long digressions, etc.).** Autistic students have difficulty understanding implicit instructions, abstract ideas, symbolic references and explanations that use intuitive reasoning.
- Do not dwell on abstract concepts for too long during a class as this can lead to fatigue and discouragement. **Illustrate ideas with examples where possible.**
- **Refer to a structured lesson plan regularly during sessions. This helps students keep track of their place in the lesson**.
- Autistic students often find it difficult to simultaneously listen and absorb information while taking notes. They are sometimes distracted by a word, or a teacher's verbal tic or body language.
- **Some experience motor coordination problems and fatigue and can be slow to take notes, thus this must be considered.** To remedy this situation, which is sometimes exhausting, several solutions can be adopted:

  1) allow the session to be recorded. It can then be replayed to pick up misunderstood passages or points not noted down, sometimes with an accelerated speed that eliminates disruptive background noises or verbal tics;

  2) provide detailed course material that includes definitions, figures and bibliographical references. This will reduce the amount of time spent compensating for comprehension problems and missing notes.

In the methods of preparing for coursework and assessment

- **If a student with autism does not wish to make a presentation, an exercise that is particularly complex to tackle in many cases, it may be appropriate to allow a written submission.** It may also be appropriate to recommend techniques and/or tools to make the task easier.

- **Autistic students have difficulties participating in group exercises** and other students are often reluctant to undertake a group activity with them. It is important to be flexible and discuss preferences with the students concerned. **If they do participate in group work, give them specific instructions to follow (who, when, what, where, how, deadline, etc.).** Insisting on specific methods can lead to anxiety and inability to complete the work.

- **Autistic students often have difficulty reading around a subject or identifying the salient points in a text.** They struggle to prioritise ideas and often cannot identify relevant information without reading the entire document. The need to interpret instructions and rules literally means they often read every source referred to. **This can lead to stress and fatigue, so it is important to provide a selection of useful readings to guide them.**

STUDENT TESTIMONY

"I have always had problems with bibliographic research. It is a source of anxiety. I can't cite books or articles if I haven't read them from cover to cover. It's not honest otherwise, it's impossible, and I don't have time to read everything that needs to be read, so I only put a few references each time. I never know whether I made the right choices. It's the same if I quote from a book, I have to read it in its entirety beforehand."

[Student with autism, May 2016]

For all written assessments and assignments, it is necessary to ensure several important elements in terms of accessibility:

1) **provide resources with explicit and clear instructions, ensuring they have a very visible layout;**

2) **indicate the length of answers expected or the number of pages required in the case of an essay**. An autistic student may not do the work requested because they can't start without knowing the parameters of the exercise;

3) **avoid abstract, implicit or overly subjective turns of phrase**. For example, questions that start with "how" often involve other underlying questions (in what way, by what means) that make it difficult to understand what is expected. **Use simple and precise instructions that don't require intuitive or hierarchical choices ('define the characteristics', 'provide a definition of', 'describe the conditions in which', etc.).**

Autistic students have recurring difficulties in conceptualising a coherent whole from diverse elements (for example, constructing an argument from several journal articles). They focus on each element without necessarily perceiving their logical links.

In addition, they have difficulty prioritising various sources of information relating to the same idea. This means that anything that is not automatic requires a significant effort to achieve. For example, putting together an essay plan requires organising knowledge based on an issue to be interpreted.

This situation therefore calls for reflection on the type of assessments and pedagogical advice dispensed so as to ensure teaching is at its most effective.

KEEP IN MIND

- High functioning autism is a cognitive disorder that is in no way an expression of an intellectual disability.
- High functioning autism affects the relationship with the external environment (i.e. relationships with others, ways of communicating and certain behaviours).
- High functioning autism causes hypersensitivity to sensory stimulation, discomfort with change and the unexpected (anything that deviates from established routines), difficulties in decoding the implicit and a lack of social skills.
- Clarity and accessibility of course materials and work instructions (transparency, clear vocabulary and straightforward meaning) can ameliorate learning problems associated with autisms.
- In classroom interactions, limiting unnecessary sources of disturbance (excessive brightness, invasive noise, etc.) is recommended.

People with high functioning autism often have a highly developed capacity for work (routine tasks requiring rigorous execution), good computer skills and hyper-observance of rules and instructions.

THE ROLE OF THE IMPLICIT IN ASSESSING COMPETENCIES

In a written general knowledge test for a competitive examination in which a French autistic student participated, a question proposed a quotation for discussion: “Do you think, like Gustave Flaubert, that the common people are eternally minors?”

The question presented an initial obstacle as it invited candidates to argue on the basis of a subjective choice (“do you think?”), an exercise that is often complex for a person with autism to carry out. The student, already familiar with these types of questions, applied his customary procedure to the preparation of his essay plan: ‘translation’ of the terms (he notes definitions of each word on a separate sheet of paper), creation of a list of ideas and related references,systematic organisation of knowledge according to its importance.

However, the word ‘mineur’ means both ‘miner’ and ‘minor’ in French. The primary meaning, ‘miner’ seemed of greater importance thanthe secondary ‘minor’. The latter had to be treated but was of lesser importance (objective hierarchy in the construction of the argument).

The student clearly identified that he was making a mistake in favouring his first definition to answer the question. However, already anxious about the challenge of the test, improvising another way of doing things would have unsettled him too much, and risked his ability to complete the work given the emotional and cognitive costs associated. He therefore favoured the comfort of abiding by his method to the letter rather than facing the impossible by reprogramming his own procedure.

DISABLING MENTAL HEALTH CONDITIONS

The precise mechanisms involved in the development of mental health conditions are still poorly understood.

In many cases, symptoms appear after a significant or painful event that acts as a trigger or precipitating factor.

However, without the cause of the symptoms and in particular their complex interactions being clearly identified, their occurrence cannot be foreseen.

As medical research advances, it has become evident that the origins of mental health conditions are to be found in a complex combination of biological, genetic, environmental, psychological (personality type) and biographical (childhood traumas, etc.) factors.

Disabling mental health conditions are diverse in terms of their symptoms, age of onset and consequences. They may occur in isolation or be associated with other types of disorders (psychological, cognitive, physical, sensory), and are sometimes a direct consequence of their symptoms (induced effects).

SOME USEFUL GUIDELINES

Mental health

Since its creation in 1946, the World Health Organization (WHO) has defined health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity."

Good mental health is therefore not simply the absence of mental or psychological disorders. It incorporates many aspects, including social and psychological factors, that may be subject either to temporary or more lasting changes.

Mental illness - Mental and behavioural disorders - Psychological disorders

There is no agreed definition of mental illness. Depending on its meaning, it can cover a very wide range of pathologies or disorders. The vocabulary is very much a matter of common sense.

In its ICD-10[12] classification, the WHO groups 'mental and behavioural disorders' under the same chapter, essentially delimiting the scope of psychiatry practice. The group labelling of these disorders covers a wide range of issues (dementia, neurocognitive disorders, sexual identity, addictions, etc.).

Mental disorders are part of a more restrictive definition which excludes disorders related to intellectual disability.

Mental disabilities - Psychological disabilities

Until the adoption of the 2005-102 Disability Act, the two terms were used indiscriminately. They are today subject to very distinct definitions. Mental disability stems from pathologies that chronically affect intellectual abilities, while psychological disability is the consequence of temporary or long-term disorders that alter behaviour or a person's general condition. It does not imply intellectual deficiency, although the use of certain faculties may be limited. The two types of disabilities may sometimes be combined.

To quote the definition offered by the *Association nationale des centres ressources handicap psychique* (the French National Association of Resource Centres for Psychiatric Disabilities): "Disability is not a statement of a person's abilities but of their situation. Beingin a situation of disability of psychological origin is defined by the totality of restrictions on participating in all areas of civic life linked to a psychological pathology. It is particularlynoticeable in the areas of daily life, relationships, social and professional life."

12. International Statistical Classification of Diseases and Related Health Problems (ICD-10), 1993 and annual updates. http://www.who.int/classifications/icd/icd10updates/en/

Although there is no consensus of agreement among experts, disabling mental health conditions are generally classified into several broad categories (this list is not exhaustive):

Mood disorders:

- the various forms of depression;
- bipolar disorders.

Anxiety disorders:

- general anxiety;
- panic disorder;
- phobic disorders;
- obsessive-compulsive disorders;
- post-traumatic stress disorder.

Psychotic disorders:

- schizophrenia;
- schizoaffective disorder;
- delusional disorder.

Eating disorders:

- bulimia nervosa;
- anorexia nervosa.

Personality disorders:

- borderline personality;
- antisocial personality;
- paranoid personality (paranoid);
- obsessive-compulsive personality;
- narcissistic personality;
- histrionic personality (hysteria).

While there may be a few clinical constants for each disabling mental health condition, the symptoms observed may be very different from one case to the next.

Moreover, regardless of the severity and diversity of the symptoms of each condition, the overall profile of the affected person greatly influences their experience of them (medical follow-up, level of support, social environment, etc.).

Furthermore, effects vary widely depending on how early certain conditions are detected.

In light of the above, disabling mental health conditions can never be understood in absolute terms, but should always be considered in relation to the individual history and the particular condition of the person concerned.

Beyond individual situations and symptoms, people with disabling mental health conditions often have a number of common traits that are important to keep in mind when considering the overall impact on their daily lives.

- In many cases a refusal to accept the presence of certain conditions leads to a late therapeutic response. This can have dramatic consequences for the people affected. Often, the earlier medical care is provided, the easier the management of the condition in the long term.
- Reluctance to seek help or accept the need for help is a common reaction.
- Relationship problems are more apparent as the condition(s) in question produce an altered perception of reality, which can directly cause difficult interactions and tensions, which in combination can lead to social isolation.
- Stigma and exclusion are common and cause suffering.
- The invisibility of some disabling mental health conditions often hides the extent of their impact on a person's daily life.
- The evolution of mental health conditions and their diverse manifestations can cause varying degrees of instability in people's lives.

Lack of awareness and understanding of mental health conditions means that they are often the subject of countless clichés and often evoke distrust, if not fear.

Furthermore, the behavioural symptoms of certain mental health conditions may deter people from offering to help. Relative lack of knowledge of a condition or of the correct pedagogical responses sometimes leads to inappropriate care and support practices (lack of support measures, tactlessness or awkwardness, denial, reactions left to individual discretion, etc.).

DEPRESSION

SOME USEFUL GUIDELINES

Depression or major depressive episode (MDE) is the most common mood disorder. The WHO estimates that 300 million people worldwide are affected by a depressive syndrome. There was an 18% increase in reported cases between 2005-2015, partly related to better diagnosis in many countries. In 2017, depression was recognised by the United Nations as the leading direct or indirect global factor of morbidity and an inability to work. It is believed to be the cause of nearly half of all suicides, while statistics for suicide attempts remain underestimated.

Depression has long been considered by some to signify a lack of character or to be the privilege of those who have nothing else to think about. It has now gained better social recognition as a condition in its own right, even if it is still the subject of various cultural clichés and perceptions.

Depression can occur at any age and is more prevalent among women, although the statistical gap with the affected male population is narrowing. It is associated with sadness and withdrawal but is distinguished from general and temporary low spirits by clearly identified clinical signs.

It is a disabling, sometimes chronic condition, and occurs independently of the patient's will. It requires appropriate medical care, which can be diverse depending on the nature of the symptoms, their severity and the profile of the affected person (background, environment, combination with other conditions, etc.).

Depression is distinct from anxiety disorders, although some anxiety symptoms may occur during a depressive episode. Depression may also be a consequence of another physiological or physical disorder. These cases require a holistic therapeutic response.

Depression is caused by a complex combination of genetic, social, biological and psychological factors and often, but not necessarily, occurs following a painful event or during a period of particular vulnerability.

Medical classifications identify nine typical symptoms of depression. It is confirmed when an individual has at least five of the following symptoms, the first two of which are present over a period of more than 15 consecutive days:

- constant sadness, with or without tears, accompanied by emotional strain;
- loss of interest and pleasure, including for activities that normally provide satisfaction;
- guilt, loss of self-esteem, social withdrawal;
- morbid ideas, a deep sense of pointlessness;
- powerful, near-permanent fatigue;
- psychomotor slowdown (difficulty doing things);
- loss of appetite and weight;
- sleep disorders (difficulty falling asleep and early awakening);
- attention, concentration and memory problems.

A moderate depressive episode comprises five to seven symptoms, while eight or more constitute a severe episode.

Beyond its clinical signs, depression is categorised into a variety of forms according to its characteristics, the recurrence and duration of episodes, or its association with other conditions.

KEEP IN MIND

- **Depression is the most common mood disorder.**
- **Depression induces deep sadness as well as a loss of interest and pleasure.**
- **Depression causes great fatigue and psychomotor slowdown.**
- **The lack of self-confidence and hypersensitivity caused by the depressive state requires a great deal of kindness, but it is important not to assume a corresponding lack of ability.**
- **It is important to ensure that the workload is spread out evenly, and to minimise the potential consequences of missed deadlines.**

The prevalence of depression among students is steadily increasingwith an associated high risk of suicide. Stress related to academic performance and/or social vulnerabilities is a contributing factor, particularly in the current economic climate, where employment is scarce.

AWARENESS AND ISSUES TO WATCH OUT FOR

During the critical phases of the symptoms of the condition, the education of students with depression is sometimes suspended *de facto*, either due to temporary incapacity or on medical advice. This is particularly the case during a melancholic episode (major depression, endogenous i.e. not attributable to any external or environmental factor) because of the high risk of suicide.

Nevertheless, most students with depression choose to remain in education with varying levels of absenteeism, and benefit from support measures (e.g. spreading out the coursework deadlines, exemption from attendance) prescribed by the institution's medical service. If necessary, they may also benefit from extra time to put together responses during examinations.

It is difficult to provide an appropriate pedagogical response because many students with depression are poorly informed about their rights or think that their symptoms will improve, and therefore don't report their health problems to the relevant university authorities. Some do, but often too late, when the spiral of failure has become entrenched.

Depression is an illness that has significant, underestimated and generally long-lasting impacts on studies. Employers recognise it as a disabling condition that justifies long periods of sick leave. How could it not be similarly disabling in a learning context?

Despite everything, catering for students with depression does not require teachers to implement major modifications to courses of study.

However, it does require demonstrating compassion and consideration, and in the moments where the impact of the condition is most severe, it is especially important to maintain a sensitive and reassuring dialogue with them.

Depressed students often display a range of symptoms that are difficult for teachers to understand:

- **they are subject to severe fatigue, psychomotor slowdown or a form of despondency due to the effects of the illness and/or the treatments;**
- they sometimes temporarily manifest certain cognitive disorders;
- **they suffer from attention deficit in class;**
- **they enter a spiral of anxiety about their academic performance and in relation to expectations;**
- they are frequently less able to perform the academic exercises required, which is traumatic and costly in terms of effort. This becomes a further source of stress and pressure (fear of not being able to manage, feeling overwhelmed by the task, etc.);
- they display hypersensitivity and great emotional fragility.

GUIDELINES AND RECOMMENDATIONS

- **Remain alert to signs of fatigue.**
- **Remain alert to signs of sadness and withdrawal.**
- Remain alert to behaviour that may suggest a high level of anxiety that is difficult to control.
- **Provide written handouts; these are more reassuring in the event of absence or inattention during a session.**
- Spread out or adapt the workload of students suffering from depression to avoid peaks of intense activity, which are exhausting and demotivating. Ideally, this should be coordinated between the teachers concerned.
- **Reassure and encourage students with depression. It is important to minimise any pressure from course work.**
- Allow students with depression to work on topics (presentations, homework) that boost or motivate them (positive dynamics).
- Finally, in consultation with the student, suggesting a relaxing and/or cultural activity within the university setting may help to offset social difficulties by providing a non-threatening social situation.

BIPOLAR DISORDER

SOME USEFUL GUIDELINES

Bipolar disorder is a severe mood disorder. It used to be referred to as manic-depressive psychosis. However, the use of this vocabulary was abandoned in the medical field because it was inappropriate and offensive. Nevertheless, it is still common in popular discourse.

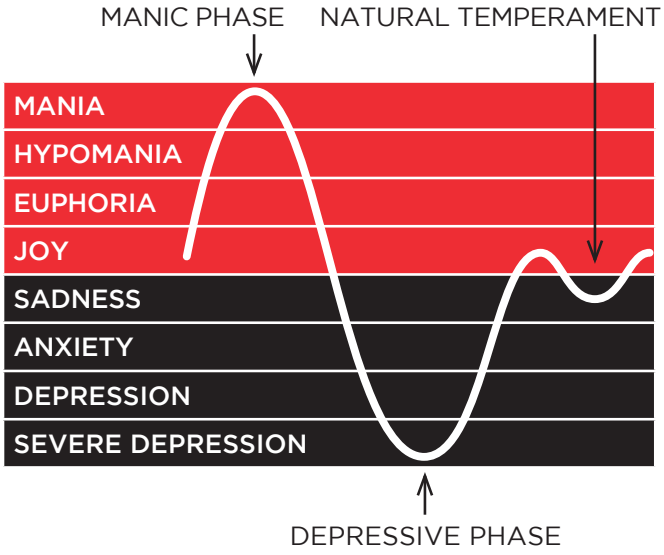
Bipolar disorder is not to be confused with the general fluctuations in mood experienced by most people. Where bipolar disorder occurs, these changes are enduring, disconnected from the lived reality, uncontrolled, and disproportionately intense.

Bipolar disorder can therefore be characterised in its typical form by abnormal variations in mood, with manic phases (in the medical sense of the term) alternating with depressive phases between periods of stability (euthymia). Mixed episodes are used to define times when symptoms of each of these phases accumulate or alternate very closely.

The duration of bipolar cycle periods varies considerably depending on the case and can occur alternately in the same day (mixed phase) or spread out over several months. Rapid cycling is generally diagnosed when four or more distinct episodes occur during a one-year period.

The manic phase, known as the 'hypomanic phase' in cases of moderate manifestation of the disorder, results in several characteristic symptoms: insomnia, agitation, elation, strong psychomotor stimulation, disinhibition.

During a manic or hypomanic phase, which must last at least four consecutive days to be diagnosed as such, the affected person has traits that differ significantly from his or her usual state.



They are a direct consequence of the symptoms and can be observed in the following signs:

- reduced sensitivity to fatigue;
- excessive carelessness;
- volubility, exuberance, hyper-sociability, over-familiarity;
- concentration problems, scattered thoughts;
- irritability, excessive reactions in social interactions;
- increased sex drive (hypersexuality), heightened sense of sexuality;
- irresponsible or reckless acts;
- increased creativity, risk-taking, entrepreneurialism;
- prophetic thoughts, feelings of grandiosity;
- feelings of invincibility and power, megalomania.

The depressive phase is defined by the common symptoms of depression. Its most severe expressions are described as 'melancholic' episodes and are considered to be a psychiatric emergency because of the high risk of suicide.

These episodes are often accompanied by delusions (visual and auditory hallucinations), profoundly self-denigrating beliefs and a deep sense of despair, self-destruction (refusal to eat, uncontrollable excesses). In the most extreme cases, the affected person freezes completely (catatonic syndrome), thus requiring a rapid therapeutic response.

The forms, manifestations, duration of the episodes and ways in which bipolar disorders play out are diverse and individual, making it particularly difficult to generalise.

It is for this reason that the term 'bipolar spectrum disorders' is now used to describe the variety of situations related to this pathology.

Although this is not the case for all the forms observed, bipolar disorders are generally separated into three main types on the basis of their severity:

- **cyclothymic disorders** present moderate and sometimes very short excitable episodes (hypomania) and depressive episodes;
- **type 2 bipolar disorders** present moderate excitable episodes (hypomania) and depressive episodes of varying intensity, from minor to very severe;
- **type 1 bipolar disorders** present severe manic or mixed episodes and depressive episodes of variable intensity. Some may not ever experience depressive episodes.

Beyond the official typologies, some specialists go so far as to distinguish seven or eight disorders within the bipolar spectrum.

The origins and severity of bipolar disorders are the result of a complex and evolving interaction between genetic, biochemical (including disrupted dopamine and noradrenaline regulation), environmental, biographical and psychological factors.

Manic or depressive phases are sometimes triggered or accentuated by external factors (a difficult period in life, a painful event), but these are not systematic causes. The same is true for bio-environmental factors (seasonality, impact of sunlight). However, manic episodes are more frequent in summer and depressive episodes are more frequent in winter.

Bipolar disorders remain widely underdiagnosed or misidentified. In many cases, they are detected late. The average diagnostic delay is 9 years. This is all the more problematic as the patient frequently refuses to accept the initial diagnosis, and often fails to comply with treatment. A delay in treatment greatly increases the severity ofthe illness. Indeed, when not stabilised, bipolar disorders can have dramatic consequences for those affected.

Among the most frequent consequences:

- a strong propensity for addictions (alcoholism, drug addiction);
- an abnormally high suicide rate;
- relational, emotional and professional difficulties;
- financial and legal difficulties.

In this regard, the WHO ranks bipolar disorders among the 10 most costly and disabling conditions.

AWARENESS AND ISSUES TO WATCH OUT FOR

It is difficult to generalise about the care and support measures for bipolar students. Not only is every individual different, but the approach depends on the severity of the symptoms experienced and the degree of stabilisation after treatment. It is important to consider the extent to which the person accepts the condition, as this influences their ability to observe a healthy lifestyle and to follow behavioural and cognitive therapies or benefit from psychopedagogy (knowledge of the disease and a reflexive relationship to its manifestations to better control it), two complementary treatments that are now common, and which are producing significant results.

It is therefore advisable to watch closely for any significant signs that may appear during a semester, such as obvious changes in behaviour in class, an unexplained drop in results, behaviours typical of a manic phase (agitation, excessive speaking, overfamiliarity, etc.), or a marked depressive state. Particularly unusual or inconsistent statements in a written assignment should also be seen as warning signs. As the illness is most often manifested between the ages of 18 and 30, with a high prevalence around the age of 20, university is often one of the places where the first symptoms present.

Prejudices relating to bipolar disorders are prevalent at all levels of society. Students with the disorder therefore rarely declare their condition out of self-preservation, rather than because they explicitly want to hide their illness.

This should act as a double incentive to be on the lookout for symptoms and to report them to the university authorities without delay, even if in doubt.

Acting quickly and signalling concerns are key to offering rapid and appropriate responses. This can avoid the student concerned being left to struggle with a situation that he or she cannot control, which is potentially dangerous and a source of suffering.

The propensity to addiction can rapidly lead to complex situations and increase the risk of dropping out. If this appears to be the case, a trusted person from the institution can offer support and help the student to accept a suitable healthcare approach.

Bipolar students sometimes benefit from course modifications during their studies.

Their treatment-related tiredness may also necessitate the provision of extra time to put together responses during written assessments.

However, taking the appropriate measures to accommodate these students in class situations does not require teachers to implement major pedagogical modifications. Other than the disruptive effects that the illness can have on academic progress when the condition is not stabilised, bipolar students do not have any particular academic difficulties. In fact, they often have a much higher than average capacity and ability, even if their results may sometimes be extremely variable. However, they are subject to fluctuating and severe fatigue, for which it is important to remain vigilant. They also display hypersensitivity and high levels of emotional vulnerability.

It is essential to demonstrate kindness, especially in the event of therapeutic supervision. Relapses potentially cancel out the most fervent efforts and extinguish motivation.

An essential issue to watch out for

Chronobiology significantly influences the long-term stability of the illness and the everyday prevention of manic or depressive episodes.

In the same way that stress or anxiety situations are known to have deleterious effects, disruptions in biological rhythm have a negative influence on control of the neurotransmitters affected by the condition.

Thus, in addition to a balanced diet and abstinence from alcohol or toxic substances, regular sleep patterns, the quantity of rest, the quality of the recovery phases, combined with disciplined organisation of the day (avoiding peaks and troughs of activity) are of primary importance to guarantee good synchronisation.

In the study environment, it is therefore necessary to be vigilant during events or occurrences that can upset this delicate balance: examination periods; periods of peak workload (accumulation of assignments); internship periods; extracurricular travel.

Time zone differences, particularly to the east, can significantly affect the biological rhythm of people living with bipolar disorder and increase the risk of a psychological crisis. It is vital to prepare well in advance of a trip abroad, particularly within the framework of university exchanges.

GUIDELINES AND RECOMMENDATIONS

- **Remain alert to signs of fatigue.**
- **Remain alert to signs of inappropriate behaviour (agitation, over-familiarity, etc.) or unwellness.**
- Spread course workload evenly to avoid intense peaks in activity, which are significant stress factors and are not conducive to stability. Ideally, this should be coordinated between the teachers concerned.
- **Encourage and support bipolar students, providing regular reassurance.**
- Whenever possible, allow students with bipolar disorder to work on topics (presentations, homework) that boost or motivate them (positive dynamics).
- **Encourage individual rather than group activities and assessments, or allow students to select their classmates for teamwork.** Students with bipolar disorder sometimes have difficulty participating in group exercises, but at times it is other students who are reluctant to undertake a group activity with them. Flexibility is advisable.
- **Students with bipolar disorder frequently have associated cognitive difficulties, such as deficits in concentration and alertness.** It is therefore important to limit disturbances in class (noise, interference, breaks in the flow of a session, etc.). At the beginning of the session, it may be useful to recap the previous session and give an overview of the current one. It is also advisable to provide work instructions in writing.
- In consultation with the student, a suitable cultural or sporting activity (e.g. yoga) can be suggested to promote social cohesion and control stress.

KEEP IN MIND

- **Bipolar disorder is a disabling mental health condition characterised by enduring, uncontrolled and abnormal variations in mood.**
- **Bipolar disorder induces deep sadness, as well as loss of interest and enjoyment during depressive phases, and excessive behaviour during the manic or hypomanic phases (insomnia, agitation, disinhibition, etc.).**
- **Bipolar disorder causes great fatigue and some cognitive difficulties in learning situations (attention, task implementation, etc.).**
- **The lack of self-confidence and hypersensitivity caused by the depressive state requires a great deal of compassion, but it is important not to assume a corresponding lack of ability.**
- **It is important to ensure that the workload is spread out evenly and to minimise the potential consequences of missed deadlines.**

ANOREXIA

SOME USEFUL GUIDELINES

Anorexia nervosa is the most common and severe of the eating disorders.

It is characterised by an obsessive fear of weight gain, which is accompanied by a distorted perception of one's own morphology. It is a pathogenic form of control relating to the vital physiological need to feed oneself and **is not related to a physical loss of appetite.** On the contrary, anorexia sufferers feel hungry, but try to control (deprivation) or thwart this (vomiting, taking medication). The more they succeed, the more they push their limits, reinforced by the satisfaction of having overcome this challenge.

Anorexia nervosa is commonly associated with another eating disorder, bulimia nervosa, as the two diseases can alternate in phases or follow on from one another over time.

Clinically, anorexia nervosa is characterised by a variety of specific medical criteria that distinguish it from the many diets that are followed for aesthetic or even social reasons.

Possible causes are multiple and cumulative (sociopsychological factors, genetic predispositions, childhood traumas) specific to the individual concerned. This makes it impossible to predict its occurrence. However, it is widely accepted that the development of anorexia is the result of many psychodynamic elements.

The manifestation of the condition, which develops gradually and insidiously, is often preceded by an unsettling event in the person's life (bereavement, family tensions, failure, etc.).

Anorexia nervosa commonly emerges during adolescence and in many cases is correlated with the changes associated with this period in life, such as sexual development and the transition towards adulthood (difficulty in asserting identity, in accepting the physical changes of puberty, low self-esteem).

Malnutrition linked to anorexia nervosa can cause many complications (cardiovascular, metabolic, neurological, etc.) and other implications (growth delays, osteoporosis, early tooth wear in the case of repeated vomiting).

In addition, the condition has significant repercussions on the social and emotional life of people with the illness, further accentuating its common psychological factors (eating disorders, ritualised behaviour, inflexible attitudes).

Anorexia nervosa leads to a fatal outcome for around 5% of patients, most often by cardiac arrest. It has one of the highest suicide rates of any mental health condition at just over 25% of associated deaths.

Anorexia nervosa is cured in the majority of cases at the end of a pathological phase (generally lasting between 18 months and five years), while nearly one in five patients retains chronic symptoms.

The vast majority of those affected by anorexia nervosa are adolescent girls, followed by young women, but it is on the rise among boys in the same age groups.

Contrary to popular belief, anorexia nervosa is not a class-related pathology restricted to urban and affluent areas. Often assumed to be peculiar to melancholic middle-class girls, it is nevertheless present across the spectrum of all social categories and its incidence is comparable in all geographical areas.

AWARENESS AND ISSUES TO WATCH OUT FOR

Anorexic students, whose education is effectively suspended during the critical phases of the disease, sometimes benefit from support measures if their studies coincide with the transitional stage after hospitalisation or periods of stabilisation.

As they are easily tired, they may also benefit from extra time to put together responses during written assessments. However, they are generally able to follow their studies normally and do not have any particular academic difficulties.

For teachers, taking the appropriate measures to accommodate these students in class situations does not require major pedagogical modifications. It is especially important to maintain a sensitive and reassuring dialogue with them during periods when the condition is severe.

Anorexic students often display a range of symptoms that can be difficult for teachers to recognise:

- **they are subject to severe fatigue and weakness as a result of malnutrition or a limited diet;**
- they are frequently very anxious about what is expected of them academically (lack of confidence, excessive willingness to do well, perfectionism, etc.), which can negatively affect the stability of the condition;
- **they are intensely invested in their education and are often highly conformist with regards knowledge and university rules, which can be a source of stress;**
- **in many cases they display a form of hyperactivity and intense intellectual activity that puts them under physical strain.** It is important, particularly in interactions in small classes, for teachers to be aware of the symptoms of anorexia nervosa (obvious weight loss and associated signs of fatigue) and to keep an eye out for vulnerable students.

GUIDELINES AND RECOMMENDATIONS

- **Remain alert to signs of illness or fatigue.**
- **Be alert to signs of physical degradation (weight loss, marked face).**
- Be alert to behaviour that suggests a high level of anxiety that is difficult to control.
- Spread workload out evenly to avoid peaks of intense activity, which are exhausting and stressful. Ideally, this should be coordinated between the teachers concerned.
- **Encourage and support anorexic students, minimising the potential negative consequences of missed deadlines.**
- Allow students with anorexia to work on topics (presentations, homework) that boost or motivate them (positive dynamics).
- Encourage the student to take renewed pleasure in doing things by giving meaning to educational activities related to the study environment. This can be a source of motivation for overcoming symptoms.
- Finally, in consultation with the student, suggesting a relaxing and/or cultural activity within the university setting may help to offset social difficulties by providing a non-threatening social situation.

KEEP IN MIND

- **Anorexia nervosa is the most common eating disorder.**
- **Anorexia nervosa is characterised by restrictive eating and an intense fear of gaining weight.**
- **Anorexia nervosa causes great fatigue and anxiety, fuelled by a quest for perfection.**
- **Suggesting subjects of interest to work on, or pleasurable activities related to the study environment can provide motivation.**
- **It is important to spread the workload evenly, and to minimise negative consequences of delayed or missed coursework.**

SCHIZOPHRENIA

SOME USEFUL GUIDELINES

Schizophrenia is a chronic psychological condition.

According to the WHO, more than 23 million people worldwide were suffering from schizophrenic spectrum disorders by 2018. In France the prevalence is estimated at 600,000 people.

Recent research on the influence of certain genes on the causes of the condition has led to estimates that around 10% of individuals are exposed to factors that increase their genetic vulnerability to schizophrenia, but do not develop it.

In France, the term 'people living with schizophrenic disorders' is now preferred to 'schizophrenic'. Although it has not had the desired effect in terms of changing perceptions, this semantic alteration aims to put the focus more on the condition than on the patient. The aim is to prevent sufferers being reduced to a set of symptoms that generate fear and stereotyping.

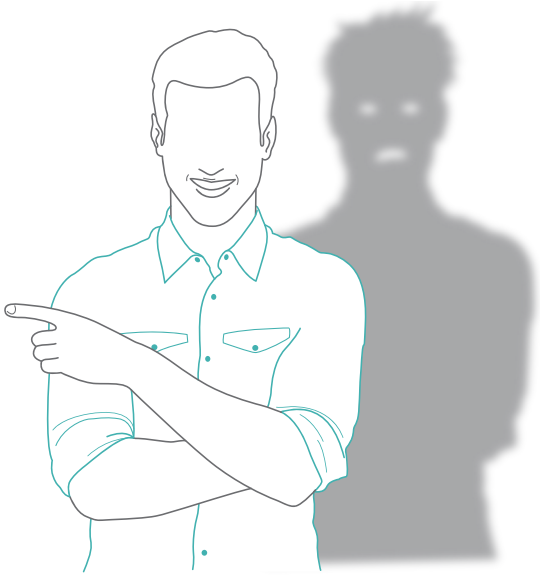
Indeed, this change in official terminology may at first seem of little importance, but it raises a significant question: how do we view people who have been stigmatised for decades? Therapeutic management of the condition has improved, resulting in greater social inclusion. Recent advances in research, particularly regarding the plurality of its causes - genetic, environmental, neurobiological and cognitive – also raise the prospects for a change in attitudes.

Schizophrenia is a generic term for a complex set of disabling mental health conditions. It is characterised by some distinctive symptoms: discordance; a distorted perception of reality; and withdrawal from social life.

These symptoms can reveal their intensity in gradual or sudden phases until reaching a critical point. The mechanisms of this are poorly understood, but it is these rare moments of crisis that underlie the negative stereotypes relating to schizophrenia.

It is, however, important to remember that this extreme expression of the illness is not the norm.

Clinical symptoms can be extremely varied, fluctuating and chronic, and bear little relation to the stereotypes. They can be grouped into three major syndromes: discordance, delusional syndrome and deficit syndrome.



These syndromes, in addition to the individual's environment and personal history, represent the framework in which schizophrenic disorders develop. The degree of severity depends on the case.

Discordance is a process that affects the normally balanced psychological functions in an ordinary individual.

It can have variable motor impacts (agitation, involuntary movements, etc.).

Discordant thinking is characterised by:

- a dissonance between the context of a situation and the response displayed (e.g. laughing at the announcement of a disaster);
- alternating emotions felt and expressed within the space of a few hours or minutes (from laughter to tears or from hatred to love).

There is an apparent lack of connection between the expression of these thoughts, which can be disconcerting.

Discordant language is characterised by:

- statements that may be incoherent or unrelated to the conversation;
- a flow of seemingly unconnected ideas;
- illogical or inconsistent answers to questions, or even the use of non-existent terms;
- incomprehensible ideas when symptoms are more extreme.

Delusional syndrome can be disturbing for those unfamiliar with its symptoms.

This phase can occur either gradually through the manifestation of strange sensations and real or supposed feelings, or it can occur suddenly and acutely.

Thought mechanisms such as the imagination or intuition can be affected by the delirium, sometimes giving the person the impression that someone else has taken control of their mind or body. The person may also remain relatively emotionally detached from what he or she perceives.

The combination of complex psychic mechanisms present in schizophrenia can sometimes lead to extremely violent seizures, but these are very rare among students in education.

Deficit Syndrome (with reality) is manifested by withdrawal, isolation, irritability and a marked lack of motivation. Social and emotional life is seriously disrupted.

Daily life, regular habits, social interaction and human contact are all experienced as if detached from reality.

Relationships with others are often experienced aggressively, pushing people living with schizophrenia to avoid social contact and isolate themselves. Drugs and alcohol are often used to try to reduce anxiety and cancel out feelings of emptiness.

The precise triggers of schizophrenia are still poorly understood, but the first signs are usually observed in post-adolescence, between 18 and 35 years of age. Some early signs may appear in children as young as eight years old.

Schizophrenia can begin with depression, addictive behaviours associated with outbursts of delirium, and eating disorders, or may develop more gradually without any other associated symptoms and lead to an acute phase that necessitates hospitalisation. It usually occurs when certain environmental factors are present (cannabis use, etc.).

People in the family or school environment notice repeated instances of absence, increasing detachment from academic work and assessments, withdrawal, listlessness, and, frequently, poor personal hygiene. Any action then requires considerable energy. When faced with an individual who exhibits these symptoms, conflicts can set in, exacerbated by anxiety attacks and violent episodes.

Acceptance of the diagnosis, when it is made, may take time. The process can be lengthy, with relapses and breaks in treatment. After a while, patients with schizophrenic disorders generally accept treatment regimens and are more inclined to limit pathogenic sources (alcohol, drugs, sleepless nights, etc.).

Their lifestyle must be regulated to ensure a balanced management of sleep, diet and medication.

Any care offered should be part of the comprehensive management of the patient and aim to reduce negative symptoms and protect the patient from unfavourable environments. Medications are strong and it can be difficult to determine the correct dosage; in addition, they have a significant impact on daily life (fatigue, etc.).

The majority of people living with schizophrenic disorders experience long-term remission, but this depends on several factors:

- the form and severity of the disorders;
- the emotional environment and psychosocial support;
- early access to appropriate medical care;
- compliance with treatments (medication, therapies, cognitive remediation).

For a growing number of people with schizophrenic disorders, a fulfilling family and professional life is possible after a few years of consistent care.

However, 20-30% of the individuals treated do not correctly follow their treatment due to the severity of their symptoms or the social isolation they experience, and relapse.

In these cases, or in certain acute phases, it is important to know that individuals with schizophrenic disorders are mainly a danger to themselves and are very rarely a danger to others.

Recent research has focused on the cognitive disorders induced by schizophrenia. Deficits in memory, attention, planning and organisational skills are clearly identifiable in almost all diagnosed cases. It therefore seems important to consider them influencing factors, and also reasons for intervention on a return to education or work.

Cognitive remediation is one of several interesting approaches to consider in the management of schizophrenia.

Two types of cognition are involved in the observed disorders: cold cognition (memory, attention, executive functions) and hot cognition (emotional, social).

Hot cognition is the subject of significant debate because it is at the forefront of success factors in social reintegration, for example after a period of hospitalisation.

Cognitive remediation therapies seem to make a major contribution the pursuit of further studies, a career or family life. A better knowledge of the influence of cognition on the condition also helps to combat prejudice.

In this respect, schizophrenia raises acute questions about the relationship between normal and abnormal, tolerance and intolerance, reason and folly. These paradoxes often lead to rejection, which prompts distance or exclusion.

In the university setting, a stable student undergoing treatment can follow a traditional educational path, assisted by some modifications to courses of study that reduce stress and the mental workload.

In some cases, students benefit from additional one-to-one help with daily organisation (medication, class schedules, appointments, etc.).

As progress is made, and in conjunction with the medical opinions of the Inter-University Preventive Medicine-Health Promotion Service (SIUMPPS) or the student's psychiatrist, these support measures can be increased or reduced.

However, the main difficulty for a person living with schizophrenic disorders is the consistency of their behaviour. In an environment that encourages competition and teamwork, the symptoms of schizophrenia, often triggered by stress factors, are rarely well received or accepted.

AWARENESS AND ISSUES TO WATCH OUT FOR

There are no general instructions regarding students with schizophrenic disorders, but there are some guidelines that can be adapted to the individual student.

First of all, it is advisable to watch closely for any symptoms that might appear during a semester. Because the illness occurs mainly between the ages of 18 and 35, university is often one of the places where the first symptoms are expressed and where initial care takes place.

It is essential to demonstrate compassion, especially in the event of therapeutic supervision. Relapses can cancel out the most dedicated efforts and extinguish motivation.

Given the stigma attached to schizophrenia, students with the disorder rarely declare their condition. This is usually out of self-preservation rather than because they explicitly want to hide their illness.

This should act as a double incentive to be on the lookout for symptoms (incoherent speech, detachment, isolating behaviour, angry or violent reactions) and to report them to the university authorities without delay, even if in doubt.

Acting quickly and signalling concerns are key to offering rapid and appropriate responses and to developing a precise picture of the situation. This reduces the risk of students experiencing situations that they cannot control, and which are potentially dangerous.

If necessary, a person from the institution in a position of trust can offer support and help the student to accept a suitable healthcare approach.

In addition, for a condition that evokes many clichés, availability of information in the university environment is central to reducing stigma and promoting early diagnosis.

Rapid and appropriate medical care, combined with cognitive therapies, can improve the student's situation and support their continuing full-time education, thus facilitating their transition to employment in the long term.

Teaching staff is ideally placed to identify symptoms. For this reason, awareness is key to enabling them to act confidently in the student's interest.

GUIDELINES AND RECOMMENDATIONS

- **Remain alert to signs of fatigue.**
- **Remain alert to signs of illness (agitation, incoherent speech, absences, etc.).**
- Remain alert to signs of severe and uncontrollable anxiety.
- Encourage and support students living with schizophrenic disorders as much as possible.
- **Spread the workload evenly to avoid intense peaks in activity, which are stressful and should be avoided. Ideally, this should be coordinated between the teachers concerned.**
- Allow students with schizophrenic disorders to work on topics (presentations, homework) that motivate them (positive dynamics).
- **Distribute course materials or documents in advance to avoid the cognitive overload induced by note-taking.**
- Ensure that exam or presentation instructions are as explicit as possible.
- **Encourage individual rather than group activities and assessments, or, if necessary, allow the student to select classmates for teamwork.** Students living with schizophrenic disorders sometimes have difficulty participating in group exercises, and their symptoms can discourage other students from working with them. It is advisable to employ a flexible approach.
- Limit disturbances in class (noise, interference, breaks in the flow of a session, etc.) to avoid difficulties with concentration. At the beginning of the session, it may be useful to give an overview, and to recap the previous session. It is also advisable to provide any instructions in writing.
- Finally, when a balance is established, particularly in the case of therapeutic care, practising a gentle physical activity in a calm atmospherecan be suggested to the student to reinforce the calming nature of his or her study environment (e.g. Pilates, yoga or sophrology).

In critical situations:

- avoid using a dry or reproachful tone of voice so as not to provoke provoke an aggressive response. It is important to remain clear, sympathetic and assertive;
- try to limit conflict;
- when faced with speech that is incoherent, absurd, disconnected from reality, or the expression of bizarre thoughts, it is important to remain calm and avoid brutally questioning the statements made.

KEEP IN MIND

- **Schizophrenia is a mental illness that covers a range of complex disorders.**
- **Schizophrenia can induce a series of discordant atypical behaviours that have a distorted relationship with reality and/or lead to withdrawal from social life.**
- **Schizophrenia causes great fatigue and some cognitive difficulties in learning situations (attention, carrying out tasks, etc.).**
- **It is important to ensure that the workload is spread out evenly, and to minimise any negative consequences of delayed or missed coursework.**
- **Properly stabilised and given the correct medical attention, schizophrenia does not represent an obstacle to the successful pursuit of studies.**

CONCLUSION

METHODOLOGY

This work originated from a project on pedagogical innovation, cognitive disabilities and disabling mental health conditions in a higher education context, under the 'Innovative Pedagogies' call for projects issued by the Community of Universities and Institutions (COMUE) Université Sorbonne Paris Cité (USPC), with the support of the Investissements d'Avenir Programme.

Its aim was to develop information and awareness-raising tools on the management of cognitive disorders and disabling mental health conditions within higher education, as well as appropriate pedagogical resources for teaching and educational teams.

In June 2016 the project resulted in the first edition of this guide in a different version.

The second edition - reviewed, expanded and restructured - was carried out with the support of the Agefiph and the FIPHFP.

The guide was initially based on the conclusions of an empirical survey carried out at Sciences Po during the 2015-2016 academic year:

1) a questionnaire completed by a representative group of 260 teaching staff, which consisted of four parts: an assessment of the level of information about cognitive disabilities anddisabling mental health conditions; feedback on experience; a needs assessment; and a survey of opinions on a few specific issues (the provision of support for students, the adaptation of teaching methods and of knowledge assessment methods);

2) a questionnaire completed by 47 students with disabilities, which comprised two parts: feedback on their experiences and a survey of opinions on issues similar to those in the questionnaire for teaching staff;

3) a series of qualitative interviews with teachers, educational staff and students.

This was complemented by insights and testimonies collected from teaching and administrative staff at other higher education institutions.

The content was based on the evaluations of a series of pedagogical experiments carried out at Sciences Po between February and May 2016, then in 2017, with the assistance of teachers and student volunteers

The experiments were of four kinds:

- the implementation of strengthened individualised support measures for some vulnerable students with cognitive disabilities or disabling mental health conditions;
- tests to adapt course materials and their methods of use;
- suggestions for educational resources (information, good practices) teachers of students with cognitive disabilities or disabling mental health conditions;
- a metacognition workshop in partnership with McGill University and supported by the Samuel de Champlain Programme.

Advice on the implementation of some of the experiments was provided by experts.

Throughout its development, from the design of the approach to the proofreading of the drafts of the guide, the work carried out has benefited from the advice of a panel of practitioners and confirmed experts as well as from professionals and representatives of disability support organisations.

Finally, the project involved extensive documentary research and the processing of information of various kinds (research literature, reports and institutional texts, documents produced by disability support organisations).

ACKNOWLEDGEMENTS

This endeavour involved numerous stakeholders. Their generous support was essential to its completion.

We warmly thank:

- all the practitioners, experts and representatives of disability support organisations who were consulted for the project;
- the Sciences Po directors and management staff who resolutely supported the project;
- the Sciences Po teaching staff who took part in the experiments;
- the Sciences Po teaching staff who shared their comments, feedback and points of view;
- the Sciences Po teaching staff who responded to the project questionnaire;
- the Sciences Po administrative staff who made it possible, at all levels, to carry out the experiments and manage them successfully;
- the Sciences Po administrative staff who shared their comments, feedback and opinions;
- the Sciences Po students who took part in the experiments;
- the Sciences Po students who shared their comments, feedback and opinions;
- the Sciences Po students who responded to the project questionnaire;
- personnel from other higher education institutions, teaching and administrative staff who provided important insights.

The following people should also be particularly thanked for their involvement, attention, valuable advice and encouragement:

- **Jean-Louis ADRIEN,** University Emeritus Professor (Psychology), former director of the *Institut de Psychologie de Paris*;
- **Stéphane AUZANNEAU,** Director of Information Systems, lecturer (Economics), Sciences Po;
- **Eva AUZOU,** researcher (Educational Sciences), Sciences Po;
- **Florence BARRUEL-SINIMALE,** psychologist, *Groupe hospitalier intercommunal Le Raincy - Montfermeil*;
- **Simon BECK,** psychologist, autism expert;
- **Camille BENOIT,** psychiatrist;
- **Maurice CORCOS,** Professor of Child and Adolescent Psychiatry (University of Paris Descartes), Head of Department of Adolescent and Young Adult Psychiatry at the *Institut Mutualiste Montsouris de Paris*;
- **Aurore LAMBERT,** Secretary General of the *Revue française des affaires sociales*, lecturer (Political Science), Sciences Po;
- **Denis LEGUAY,** Hospital Psychiatrist, Secretary General of the French Committee for Psychosocial Rehabilitation;
- **Jean-Christophe MACCOTTA,** psychiatrist;
- **Bojan MIRKOVIC,** psychiatrist;
- **Tina MONTREUIL,** assistant professor(Psychology), McGill University;
- **Bernard PACHOUD,** psychiatrist, Professor of Psychopathology (*Université Paris Diderot*);
- **Jérôme PELISSE,** university professor (Sociology), Sciences Po;
- **Anne REVILLARD,** associate professor (Sociology), Sciences Po.

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