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The special educational needs of adolescents living with chronic illness: a literature review

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Rates of chronic illness are increasing around the world and, accordingly, numbers of adolescent students living with chronic illness are also increasing. The challenges faced by these students and their teachers are complex. One of these challenges is the need of the adolescent with chronic illness to achieve some level of social conformity. Another major hurdle in the educational setting for adolescents living with chronic illness is dealing with the needs of others. Enduring the restrictions of illness is a challenge for all who live with chronic conditions, but is particularly demanding for adolescents in regard to their education. Appropriate and open communication is an area of particular concern for students with chronic illness. Within the challenges, there can also be opportunities for empowerment, through developing resilience. There must be more general understanding on the part of educators of the nature and impact of the various medical conditions which students living with chronic illness present. Communication is possibly the area of highest priority for teachers and schools to improve in relation to the education of students living with chronic illness. Closely linked with the issue of communication are the matters of managing school absence and the role of digital technologies.

Keywords: adolescence; adolescents; education; chronic illness; communication

Introduction

As a parent of two adolescents living with chronic illness and as a classroom teacher, for many years the researcher has been involved in the process of advocating for her children and her students in their education. Over time, the complexity of the negotiation processes and the frustrations experienced by students and their parents have inspired the researcher to begin the formal study which lead to the production of this paper. Initially, the research was conducted to discover whether the author's experience was unique. Unfortunately, it has become apparent that the struggles of this parent and her children have been replicated many times in many countries.

Thus far, this research has been focused on the literature, through academic journals and other publications. In early 2011, the keywords 'adolescent'; 'adolescence'; 'chronic illness' and 'education' were used in searching the various databases linked through the University of Canberra library. The definitions of these keywords, as used in this paper, can be found in the Glossary. The original search only identified

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25 documents. After broadening the search, a total of 108 documents were obtained for review.

The review of the literature on the education of adolescents living with chronic illness conducted by the researcher suggests that these students and their teachers face challenges which are many, complex and varied. Foremost of these is the need on the part of the adolescent with chronic illness to conform to the physical and social standards of their peers. Another major hurdle in the educational setting for adolescents living with chronic illness is their interaction with the needs, expectations and behaviours of others. Living with chronic illness can be very demanding of time, energy and strength of will; all required for success in education. Successful communication between the various stakeholders in the health and education of adolescent students living with chronic illness is vital. While there are many challenges for adolescent students living with chronic illness and their teachers, there is also the possibility of empowerment for the student, through the development of resilience.

Before the special educational needs of adolescents living with chronic illness are examined in detail, it is useful to have some understanding of the history of the relationship between education, adolescents and chronic illness. The current focus on inclusion is 'neither an Australian nor a recent phenomenon' (Shaddock, Giorcelli, and Smith 2007, 3). Since the passage of the Handicapped Children Act in the USA in 1975, there have been dramatic changes in societal and individual approaches towards people with disabilities. Anecdotal reports sourced from several experienced teachers who have taught across various education sectors and jurisdictions through the last 40 years suggest that awareness in schools of the challenges facing students with disabilities and their teachers has gradually increased. These discussions are supported by the literature on the history of inclusion and normalisation in schools (Ashman and Elkins 2009; Thomas and Vaughan 2004). While there was apparently little or no formal process for meeting these needs in schools in the 1960s and 1970s, by 2011 there is a much greater awareness of the rights and responsibilities associated with the provision of an inclusive education for students with disabilities. In the twenty-first century, many 'education Acts distinguish between students generally and students with disabilities' (Ashman and Elkins 2009, 39). The moves to inclusion have come from many different directions through 'the imperative to greater social justice' (Thomas and Vaughan 2004, 1). One of the challenges for students with chronic illness is whether or not their condition fits into the definitions of disability. As Berland (2009) suggests, the usual distinctions between diagnoses of illness and disability becomes blurred in this situation, 'because illness implies a particular temporal relation – you get sick, you get well' (700).

Needing to conform

Being normal – a state of conforming to what is usual, typical or expected – is of course a highly subjective concept. There are aspects of normalcy which are not limited to conformity. For many people living with chronic illness, being normal, i.e. living a life similar to that lived by other people without chronic illness, appears unobtainable. The healthy 'have the luxury of a life without choices' (Miseradino 2010). For those living with chronic illness, being normal may be the process of acting 'in such a way as to limit the influence of the illness on the life as much as possible. Trying to retain self-control, make decisions and be responsible in daily life seems to be important' (Ohman, Sonderberg, and Lundman 2003, 531) in making life something

approaching normal. The complete scope of defining and exploring ‘normal’ for those living with chronic illness is beyond the capacity of this paper. In examining ‘normal’ for the adolescent living with chronic illness, the researcher has chosen to focus upon the issue of conformity.

Adolescence is the period of human development when conformity to the group is often of paramount importance for the individual:

peers influence orientations to adolescent culture such as matters of taste, style and appearances . . . The quality of peer relationships is associated with students’ academic orientation and school performance . . . and the development of social competences and successful relationships in later adulthood. Developing close friendships and belonging to peer groups provides adolescents with an opportunity to share common issues and develop coping strategies . . . Such social networking provides adolescents with a sense of connectedness. (Foreman 2011, 491)

For the student with chronic illness, this typical adolescent focus can be particularly fraught through the complications associated with their condition. The characteristic adolescent fears and anxieties about body image, self-identity and future role in society are magnified by illness (Ainsa 2001, 400). In striving for normalcy, adolescents with chronic illness must learn to live with fatigue, pain, reduced strength and in some cases impaired mobility (Dailey 2010, 7).

Body image and self-identity are closely linked. The effects of chronic illness and its treatment may make the student ‘look and feel different at a time when he or she has a strong need to conform’ (Ross and Scarvalone 1982, 256). The interplay between physical appearance and disease is so significant in adolescent students that it is the most prevalent cause for referral to mental health intervention to facilitate school re-entry (Sexson and Madan-Swain 1993, 118). Students who have been living with chronic illness for years are at increased risk for anxiety, depression and low self-esteem (Shaw and McCabe 2007; Wodka and Barakat 2007). For many, the ‘loss of control over the body . . . might create a feeling of insecurity that can inhibit one’s ability to explore and learn’ (Aujoulat, Luminet, and Deccache 2007, 783). Medical treatments, special diets, medications and physical changes are, for students with chronic illness, constant daily reminders of their dependence on medical support and their separateness from their peers (Shiu 2001, 270). For some students, the desire for normalcy may have potentially serious consequences, as they seek to prove themselves despite their condition. Such action may actually jeopardise students’ well-being as well as their capacity for academic success (Dailey 2010; Velsor-Friedrich et al. 2004).

The challenges of dealing with the fatigue associated with chronic illness and its treatment are mentioned frequently in the literature. Indeed, it seems reasonable to consider fatigue and its effects on attention and memory as one of the common symptoms shared between those living with different chronic conditions (Jackson 2006, 67; Kaffenberger 2006, 36; Shaw and McCabe 2007, 75; Shiu 2001, 271–2; Thies 1999, 394; Velsor-Friedrich et al. 2004, 141). Fatigue, pain, reduced strength or impaired mobility are in direct conflict with the invincibility fable perpetuated by adolescent egocentrism (<http://www.saskschools.ca/~psychportal/Psych30/egocentrism.htm>; Velsor-Friedrich et al. 2004, 142–3).¹ This conflict is another component in the increased risk for anxiety and depression discussed earlier. The effects of pain and fatigue on academic capacity are not always obvious to teachers and other school staff.

Dealing with the behaviours of others

Adolescents can be dramatically affected by the behaviours and attitudes of others. To some extent, this is a function of the need to meet group expectations; to 'conform to the norms of the group and to demonstrate commitment and loyalty to other group members' (Santor, Messervey, and Kusumakar 2000, 163.) However, the behaviours of peers, teachers, parents and other school staff regarding students with chronic illness can have a dramatic effect on social, psychological and academic outcomes for these students.

When using the medical model of disability, schools react to chronic illness with a problem or deficit approach (Thies 1999, 393). A more empathetic approach, through a social model of disability, will ensure that the students themselves are more actively involved in their interactions with education. The social model shifts the obligation for and responsibility for change from the individual living with chronic illness to the 'built environment and social arrangements that are organised around norms of able-bodiedness' (Jung 2001, 181). Successful management of both chronic illness and its interaction with education depend upon the active involvement of the student (Lightfoot, Wright, and Sloper 1999, 268; Michie, Miles, and Weinman 2003, 197). Indeed, 'the school may represent the only place where the chronically ill student can be viewed as a person rather than a patient' (Shiu 2001, 273).

The attitudes and responses of individual teachers can dramatically affect the academic success of a student with chronic illness. Ideally, educators should be aware of potential risks 'and inform themselves about the behaviours, signs, symptoms, health consequences and preventive strategies' (Vaschenko 2005, 20) associated with the chronic illnesses present in their classrooms. Unfortunately, we do not live or teach in an ideal world. Far too often, through communication breakdown, lack of teacher time, lack of clarity regarding school policies and roles of school staff, or lack of interest, teachers are uninformed about the special needs of their students who are living with chronic illness (Shiu 2001; Strawhacker and Wellendorf 2004; Thies 1999; Thies and McAllister 2001). In dealing with chronic illness, there is often a level of scepticism from teachers which students must overcome (Njoku 2008, 6). In part, this scepticism flows from the fact that unlike physical disability, chronic illness presents as an invisible disability as the condition is often not clearly marked on the body (Berland 2009, 699; Jung 2001, 190).

Just like teachers, the attitudes of peers towards the student living with a chronic illness can present obstacles to academic engagement and subsequent success. When confronted by a friend or acquaintance of their own age who is managing major health challenges, many teenagers find their world view threatened, and often do not know how to respond (Kaffenberger 2006, 36). Alternately, other students will be concerned that they may 'catch' the disease from their classmate (Jellinek, Bostic, and Schlozman 2007, 80; Sexson and Madan-Swain 1993, 117). Some healthy students will resent any accommodations made for the student with chronic illness (Berland 2009, 703; Ross and Scarvalone 1982, 257). Often, the response of peers is to ostracise or ignore the student living with chronic illness (Lightfoot, Wright, and Sloper 1999, 277; Mukherjee, Lightfoot, and Sloper 2000, 64; Sexson and Madan-Swain 1993, 118). Overcoming these attitudes is a major challenge for the student living with chronic illness, particularly for those battling terminal conditions. These students need to be assured that they will not be 'isolated, deserted or denied hope' (Ainsa 2001, 400).

Enduring the restrictions of illness

The nature and level of restrictions to be endured by students living with chronic illness vary widely, depending on the nature of the condition. For some students, the effects of illness may simply be bothersome, such as remembering to carry an asthma inhaler. For others, the restrictions enforced by their illness can interfere with daily living as well as affect classroom performance. As previously discussed, one common restriction is fatigue ‘the universal symptom’ (Dailey 2010, 12), and the difficulties associated with finding the time to rest and become rejuvenated.

Another restriction commonly faced by students with chronic illness is high levels of school absence. Students with chronic illness are absent from school for an average of 10 days in a year, compared to around 3 days absence for healthy children (McDougall et al. 2004, 43). Whether these absences are part days for attending medical appointments, short absences (often 1–3 days) or extended absences caused by hospitalisation and recovery, cumulatively these absences can lead to low levels of academic attainment, social isolation, increased disadvantage and low levels of motivation (Dyson et al. 2007, 584; Sexson and Madan-Swain 1993, 118). The patterns of absence and nature of the conditions concerned make it difficult for students living with chronic illness to achieve their potential (Thies 1999, 395). School avoidance or even school phobia can be a side effect of the stress and fear of failure associated with extensive absences. It is significant that there is a 10% incidence of school phobia in US students with chronic illness, in comparison with the general population incidence of 2% (Henning and Fritz 1983, 261). A South Australian study sets Year 7 absentee rates for the general population at 3.5% (Rothman 2001, 62), though this study does not examine students living with chronic illness.

Open communication

The issue of communication is prevalent in the literature discussing the special educational needs of students with chronic illness. Over 50% of the documents studied discussed ways that communication contributes, whether positively or negatively, to student engagement and student success in the classroom.

Successful integration of the adolescent student with chronic illness requires frequent communication between parents, school, the medical team and the student (American Academy of Pediatrics 2000, 1155; Ross and Scarvalone 1982, 257) and ongoing collaborative relationships (Bonaiuto 2007, 203). To promote optimal health for students and thus better opportunities for learning, parents, school staff, the student and medical teams must establish trust and maintain relationships (Strawhacker and Wellendorf 2004, 8). There are many challenges involved in ensuring successful and sustained communication between these groups, and different strategies are required for the different groups:

Parent–school: Parents of adolescents with chronic illness are often weary of attempting to communicate the nature of their child’s condition and its impact on education (Osgood, Foster, and Courtney 2010, 212). This situation can be exacerbated in the transition to secondary school, as there are many more teachers to consult. Another complication of free-flowing communication between parents and schools is the issue of power. Some chronic illnesses, for example, sickle cell disorder (SCD) and diabetes, are more prevalent in low socio-economic ethnic and social groups (Balcou-Debussche and Debussche 2009, 1100; Dyson et al. 2007, 581). These parents may have difficulties communicating with teachers through language or social barriers.

Student–school: As previously discussed, there are sometimes issues of scepticism which can harm the student–teacher relationship and hamper communication between the two. Unfortunately, there are simply too many examples of students with chronic illness enduring situations at school which can damage their health, due to teachers not listening to their requests for accommodations (Dyson et al. 2009, 136; Mukherjee, Lightfoot, and Sloper 2000, 63; Velsor-Friedrich et al. 2004, 145). It is important for teachers to listen to their students as ‘being heard is and can be therapeutic’ (Dailey 2010, 18). As with parent–school communication, consideration of the impact of perceived power relationships will facilitate ongoing school–student communication.

Medical team–school: Communication between schools and medical teams needs to be improved (Thies and McAllister 2001, 168). Managing chronic illness may require a multitude of medical personnel and as previously mentioned, the secondary school system incorporates multiple teachers. The primary obstacle to successful communication here is simply logistical – whose job is it to communicate with whom? It is imperative that one individual from the school (whether a teacher or another member of school personnel) be designated as the liaison with the medical team (Sexson and Madan-Swain 1993, 121). This requirement of course raises issues of time and inclination for that individual. Power issues must also be considered in this relationship – there are members of both professions who prefer the ‘top-down’, expert–novice paradigm (Kumagai, Murphy, and Ross 2009, 316). Often, school and medical staff consider that parents should act as go-betweens for school and health-care providers (Mukherjee, Lightfoot, and Sloper 2002, 22); for various reasons including those discussed earlier in this section, parents may not be able to meet this expectation. The challenges of communication between school and medical teams must be overcome, as ‘lack of adequate medical information concerning the child’s special needs . . . limits the school’s ability to meet the needs’ (Sexson and Madan-Swain 1993, 120) of the student living with chronic illness.

Within schools: Anecdotal reports from a number of teachers, parents and students which are supported in the literature suggest that one of the ongoing frustrations for parents and students living with chronic illness is the issue of communication breakdown within schools (Mukherjee, Lightfoot, and Sloper 2000, 63). The risk of communication failure is aggravated by the numbers of staff involved in secondary schools, and the recent trend towards ‘super schools’ containing up to 13 different year levels on the one campus. There are also issues relating to the briefings given to new and temporary staff (Mukherjee, Lightfoot, and Sloper 2000, 63). The role of school administrators, particularly principals, is significant (Thies and McAllister 2001, 168) in managing communication within schools to ensure that the special educational needs of students with chronic illness are reliably met across the school.

Improving resilience

Resilience – the power of springing back, of coping with stress and catastrophe – is a key concept in academic success for students living with chronic illness. It is important to note that resilience is a process to be supported rather than a personal attribute (Kralik, van Loon, and Visentin 2006, 190). As already discussed, students with chronic illness face ongoing disruption through the nature of their illness and its treatment. The capacity of the student to develop resilience will be further affected by how successful the school environment is in moving away from a medical and toward a

social model of disability, in which there is an 'emphasis on youth taking an active role in their own success' (Osgood, Foster, and Courtney 2010, 218).

Students living with chronic illness may need extra assistance in developing resilience in the educational setting. As previously discussed, the constant battle against pain and/or fatigue can leave students struggling with low self-esteem, anger and depression (Velsor-Friedrich et al. 2004, 141). Levels of student resilience will be influenced by 'the illness type and experience as well as the individual's life context and previous life events' (Audulv, Asplund, and Norbergh 2010, 99). For example, those who have been living with chronic illness since birth will often find that the cumulative demands of the illness and the journey through childhood can sap the 'ability to take on the burdens of the longer transition to adulthood' (Osgood, Foster, and Courtney 2010, 212), such as the demands of academic development. In the resilient student with chronic illness, the ongoing fight against illness and its restrictions can create an individual who is highly empathetic and an expert mentor (Dailey 2010, 13–4). Through their 'trial by fire', the student with chronic illness who is responding with positive resilience characteristics will develop the adaptability which is central both to living well with illness (Kralik, van Loon, and Visentin 2006, 193) and participation in the academic and social world of school.

Discussion

There are a number of areas which will require further attention in the future, if educators are to successfully provide effective and sensitive inclusion for adolescent students living with chronic illness.

Firstly, there must be more general understanding on the part of educators of the nature and impact of the various medical conditions which students living with chronic illness present. While conditions such as asthma have a higher profile in schools, other conditions are less well known. One such condition is SCD. SCD is an inherited blood condition that mainly affects people of African and Caribbean descent (Dyson et al. 2007, 582). Logic suggests that increasing levels of African migration (Hugo 2009, 15) will bring about increasing numbers of students living with SCD in the wider Western world. While there are units in education degrees which address the issues of educating students with special needs, there appears to be little published research on how teachers implement this learning.

The literature certainly suggests that there are still areas for teachers and schools to improve in relation to the education of students living with chronic illness. Communication is possibly the area of highest priority. One tool which is available for improving communication between students, parents, teachers and medical professionals is the Individual Learning Program (ILP). There is little information available regarding the use of ILPs by students living with chronic illness. In my own experience both as a teacher and a parent of adolescents living with chronic illness, the process of developing ILP is often as important as the actual document itself. Building a 'relationship of respect' (Kritikos 2010, 224) between students, educators and parents is pivotal to successful communication, and these relationships can be deepened through the discussions which occur in ILP development.

Closely linked with the issue of communication is the matter of managing school absence. When working with students living with chronic illness, it is not enough for teachers to ensure that returning students have copies of notes from another student's workbook (Dyson et al. 2009, 127). There is more to learning than the writing of

notes. Students with chronic illness have repeatedly highlighted the value they place on those teachers who send work home or make the time to explain the work missed (Dyson et al. 2009, 127; Lightfoot, Wright, and Sloper 1999, 272). Some teachers are highly successful in positively managing student absences – more study coupled with appropriate training is needed so that this success can reliably be duplicated by other teachers.

There are various support structures discussed in the literature which are available for students with disabilities in different regions of the world – distance education; home tuition (Everett and Fulton 2002, 30); hospital schools, which attempt to provide continuity of education (Hubbuck 2009, 48); school counsellors, school nurses and school psychologists. There are unrealised opportunities to further develop links between classroom teachers and the professionals involved in the delivery of these support structures and to examine the nature and funding of the different structures in different educational jurisdictions and compare the outcomes achieved.

The role of technology in ensuring that students with chronic illness can be absent from school but still a part of their classes is significant (Njoku 2008, 6; Pulman 2010, 21). It is unfortunate that in this Internet-based era, with its emphasis on ‘instant’ communication, many students living with chronic illness miss out on educational opportunities due to a lack of funding or awareness of the possible role of web cams, voice and video streaming, coupled with other enabling technologies which would allow these students to maintain contact with their teachers and classmates. The maintenance of contact with friends and peers is important to the adolescent with chronic illness (Ainsa 2001, 400); the innovative use of technology in the classroom is one way in which this contact can be maintained while educational objectives are also achieved.

As an Australian teacher and researcher, a point of interest is that there appears to be little Australian research on the education of students with chronic illness. Of the papers examined in preparation for this review, only approximately 3% were Australian; given that Australian students have some of the highest rates of asthma in the world (http://www.healthinsite.gov.au/topics/Asthma_Statistics) and Australia’s rate of obesity and overweight in children and adolescents stands at almost 25% (<http://www.health.gov.au/internet/healthyactive/publishing.nsf/Content/overweight-obesity>), (with all of the associated risks of diabetes and heart disease for Australian students), it seems logical that Australian teachers need more information and skills for teaching students living with chronic illness.

How schools and teachers can improve in any or all of the areas discussed throughout this paper require further research and discussion. The matter of funding and time allocation must be addressed in any plans for change. Most teachers feel that ‘time – or the lack of it – is their most significant barrier’ (Shaddock, Giorcelli, and Smith 2007, vii) to the successful inclusion of students with disabilities.

Conclusion

Success at school, while a positive outcome in its own right, is also ‘a valuable resource that enhances success in many domains’ (Osgood, Foster, and Courtney 2010, 218). As educators, we owe our students a chance at that success. At the very least, we must ensure that our actions, or lack thereof, do not have a detrimental effect on the success of our students. Students living with chronic illness have special educational needs which must be addressed. These include their need to conform with their peers; the ways in which they interact with the behaviours of others; the particular

restrictions of their various medical conditions; the complexity associated with communication between all the players in their education and the role of resilience. It is vital that these young people who have:

fought valiantly to survive medical challenges have every opportunity to complete their education satisfactorily so that they can reap the full rewards of having overcome or lived with an illness or life threatening disease. (Shiu 2001, 277)

The challenge for us as teachers is to be enablers, rather than obstacles, for these students.

Glossary

Adolescence is the period of human development characterised by accelerated processes of change in cognition and social and psychological functioning (Ashman and Elkins 2009, 309) as well as the profound physical changes associated with puberty. Most adolescents in the Western world are expected to attend compulsory schooling. Under the provisions set out by the National Partnership on Youth Attainment and Transitions, the Australian education system places most adolescent students in some form of compulsory schooling until the age of 17. In the UK, the school leaving age will be raised to 17 in 2013 and 18 in 2015 (<http://www.publicnet.co.uk/abstracts/2010/02/03/plan-for-raising-the-school-leaving-age/>). Across other countries in the developed world, the school leaving age ranges between 15 and 18. While many adolescents face physical, emotional and educational challenges as they progress through this life stage, adolescents living with chronic illness have unique educational needs.

There are a number of definitions of chronic illness found in the literature; there is no unequivocal definition of the concept of chronic health conditions in childhood and adolescence (Van Der Lee et al. 2007, 2741). Among the myriad possibilities, Dailey (2010) defines chronic illness as a condition that endures over time, which can be marked by remissions and exacerbations that create uncertainty about what lies ahead for those living with the illness. Chesson, Chisholm, and Zaw (2004, 335) suggest that the common characteristics of chronic illness are an illness with an unpredictable course; requiring behavioural adjustments; creating a long-term dependency on treatments and demanding a high commitment to self-management strategies. Barraclough and Macheck (2010) use a more rigid definition: 'a medical condition, lasting for more than 3 months, which requires medical attention and interferes with a person's daily living' (132).

Chronic illness is estimated to make up approximately 80% of the burden of disease, mental problems and injury for the Australian population as a whole (Glover, Hetzel, and Tennant 2004). Around the world, rates of chronic illness have increased dramatically. Perrin, Bloom, and Gortmaker (2007) refer to the 'epidemic growth' of childhood chronic conditions in the USA (2758). Gortmaker and Sappenfield (1984) suggest that:

although it is . . . quite difficult to obtain estimates of survival that are exactly compatible across time and diseases, such large changes have been documented during recent decades that these facts cannot be disputed . . . a doubling in the rate of survival to adulthood will lead to a doubling of the population prevalence. Furthermore, this increase in survivorship will have the effect of producing more older children (and eventually adults) with these chronic diseases. (6)

They go on to suggest that approximately 80% of children with long-term, severe chronic illness will survive into adolescence. (Gortmaker and Sappenfield 1984). In the UK, Mukherjee, Lightfoot, and Sloper (2000) suggest that most medium to large secondary schools would contain students living with chronic illness. Schools, teachers and administrators around the world are managing ‘coordinated school interventions to maximise school attendance and facilitate educational and social growth’ (Sexson and Madan-Swain 1993, 115) for all students with disabilities, including many students living with chronic illness.

Note

1. The use of the term ‘egocentrism’ in this paper is an attempt by the author to discuss common aspects of adolescent behaviour such as self-centredness and a sense of invulnerability, without entering into a moral judgement of such behaviour.

Notes on contributor

Megan Jackson is a classroom teacher in Canberra, Australia. She is the parent of two adolescent children who are living with chronic illness. Her parenting experience covers chronic illnesses and conditions including cystic fibrosis, gastro-oesophageal reflux disease, attention deficit disorder, asthma, anxiety, depression and obsessive compulsive disorder. Having recently completed a Masters in Inclusive Education through the University of Canberra, Megan is currently working towards a PhD in Education.

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