



# Promoting the inclusion of infants and young children with disabilities in child care

Participant Module

**Promoting Full Participation**



Philadelphia Inclusion Network a program of  
Child and Family Studies Research Programs at  
Thomas Jefferson University  
130 S. 9<sup>th</sup> Street, 5<sup>th</sup> floor  
Philadelphia, PA 19107  
[cfsrp@jefferson.edu](mailto:cfsrp@jefferson.edu)  
<http://jeffline.tju.edu/cfsrp>

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# Session: Promoting Full Participation

## OVERVIEW

### What this workshop should accomplish:

All children are more alike than different -- but some children may be different from others because of their likes or dislikes, what interests them, or what they are able or unable to do. Caregivers who recognize the unique diversity among children for whom they are providing care can receive great benefits from promoting the growth and development of all children. Diversity is a challenge that can enrich the lives of children and caregivers.

Children with special developmental or learning needs can participate successfully in activities and can learn while in the child care setting. Accommodations to the physical environment of a center and the classrooms and other places (e.g., outside playground) and adaptations of activities, materials, and instructions can help promote participation of ALL children. Planning and using individualized instruction enable child caregivers to promote children's learning by using teaching strategies that mediate for and accommodate differences.

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**From this session, participants should gain understanding about:**

- i Be familiar with the relevance (or irrelevance) of labels as descriptions or representations of individuals
- i Identify ideas for changing the environment, activity, or materials so that children with special needs are accommodated
- i Recognize how to accommodate children with particular types of learning needs by individualizing curriculum, classroom activities and routines, and teaching strategies;
- i Identify general characteristics of children who have developmental concerns, delays, or disabilities..

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## BACKGROUND

Within any group of young children, child care staff can find a wide range of abilities and talents. This is illustrated by the variety of skills that can be observed in groups of children who have typical development. For example, some children may talk earlier than other children who may have advanced motor skills. Perhaps more important than the variety of skills are the different interests and talents of children. Some children like art activities, others gym, etc. while others may spend all their time on the computer, if allowed!! A caregiver may learn that a child with special needs is coming to the classroom. However, the only things they may know are the child's name and the child's diagnosis or early intervention label. Yet, medical diagnoses and early intervention labels are the least relevant information in helping caregivers provide opportunities for learning and development.

One way to accomplish individualization is to use a strengths-oriented approach. With this approach to individualization, learning opportunities and experiences are maximized for all children. The strengths-oriented approach is accomplished first by identifying each child's strengths and concerns. Second, child care personnel can make adaptations for activities and routines that are not working well for individual children. Third, child care staff use teaching strategies to build skills during activities that are going well for the child.

### Labels and Information

Labels identify a particular circumstance -- people are boys, girls, members of particular racial or religious groups, they are big, small, creative, talented, or whatever. Labels can be used to identify a characteristic that person may hold but the label does not describe the person nor provide information about how the person may behave or act under various circumstances. All boys do not act alike nor is all of their behavior different from the ways in which girls act. All African Americans or Puerto Ricans

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or people who are Baptist or Lutheran do not necessarily act alike although they may share a common characteristic of racial background or religious belief. Similarly, all children who are labeled as, for example, blind or autistic or mentally retarded are not the same although they may share the same diagnostic label with other children (or adults). If we were to tell someone about a new child who would be entering the classroom who was African American, we would have provided the teacher with very little useful information. The label would not help the teacher address the child's unique needs or plan for ways to welcome and fully include the child in the classroom environment. Similarly, providing a teacher with information such as Down syndrome does little to help the teacher prepare for the child or ensure that the child will be able to fully participate in classroom activities.

Teachers need to know all children - not just children with disabilities - in terms of their strengths, interests, and abilities. But, with children with disabilities, these strengths or a child's interests and abilities may get "lost" with the diagnostic label. People often begin to focus on children's needs, or weaknesses, rather than on the things that children are able to do. Raphael may have Down Syndrome but he is able to pass out napkins at snack, complete an art project, and work with other children in a group. He is able to point to pictures that describe the weather outside and can ride a trike, climb a jungle gym, and do the see-saw with another child. Raphael loves watching sports on TV with his dad and brothers. His father has promised to take everyone to a baseball game next summer and Raphael is really looking forward to this. Information such as this is much more helpful to teachers than knowing only that Raphael is 5 years old, functions like a 3 year old, is unable to speak, cannot write his name, and cannot recognize any letters. The ways in which we represent all children is important not only for our own understanding of their gifts and talents but also in the ways that we represent children to other people and to other children.

Child caregivers may receive only negative information about a

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child. For example, someone may call a center and ask, "Do you take Down Syndrome children?" Caregivers are likely to respond differently when asked this question than if a parent (or other person) were to call and say, "I have a five year old who I need to have attend child care. He loves art and sports and to help with things like setting the table but he has difficulty with being understood when he tries to talk and is not doing as well as other children his age in using pencils and crayons or in knowing things like letters and numbers. Would it be possible for me to visit the center with Raphael so that we could see if he could attend?" Because child care people may only first be given a label, it is important for them to learn how to elicit information that they need in order to accommodate a child within the center.

Relevant information may be obtained through an interview with the parent, observing the child during a center visit, and talking with other people who may be involved with the child and family so that child care providers develop an understanding of the child's strengths, abilities, and concerns. Understanding how the child will fit into the classroom or program emphasizes what accommodations and adaptations will be necessary for the child to successfully attend the child care program. Families have knowledge about a child's strengths, talents, and interests as well as information about ways to facilitate children's participation. Specialists often have limited knowledge about child care and early childhood programs but have information about particular areas of development or specific disabilities. A physical therapist may have no information about child care activities and routines but may know ways to help a child with cerebral palsy (or other motor disabilities) perform specific skills. A therapist may know how to help a child sit and use her arms better during a table top art activity or how to move a child from one location to another easily during transitions. Specialists can be effective teachers by showing early childhood staff how to use special techniques and strategies with children throughout the time children spend in the child care setting.

**Notes:****Promoting Participation**

Children with special developmental or learning needs can participate successfully in activities and routines in early childhood settings when early childhood staff plan activities to reflect children's strengths, and collaborate both with families and, when needed, with outside specialists. Accommodations to the physical environment of a center and the classrooms and other places (e.g., outside playground) and adaptations of activities, materials, and instructions can help promote participation of ALL children and particularly of those with special developmental or learning needs.

Adaptations can be made for children in various classroom activities such as blocks, math and manipulative, dramatic play, literacy, drawing and art, music, or science for children with specific challenges. For example, dramatic play can be adapted for children with physical disabilities by using dress up clothing that is large and can be taken on and off without requiring fine motor skills. Children with social and emotional challenges may work better when paired with another child who will initiate interactions and assist the child in using social skills. Classroom learning centers can be structured to include materials and activities that provide opportunities for children to work on specific skills such as computer keyboarding, speaking by telling a story, or by making sure that the furniture in the housekeeping area is sturdy enough for a child with physical disabilities to use as a support. By thinking through activities and the specific challenges of individual children, child care providers can adapt classroom activities.

All children need opportunities to learn and develop -- including those children who have special learning and developmental challenges. Every child with a physical disability, for example, is not going to learn to walk any more than children with severe visual impairments are going to learn to see with their eyes. Promoting participation through accommodation and adaptation provides environmental supports so that ALL children, including

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those with disabilities, have maximum opportunities to learn and develop.

**Adaptations for Specific Types of Disabilities**

Accommodations and adaptations are strategies that can be used to improve activities and routines that may not be going as well as child care staff would like and to increase the participation of children in those activities and routines. A hierarchy of least to most intrusive strategies is used to guide teacher decision making and ideas about what and how to adapt for children's needs. The least intrusive strategy is to make accommodations to the physical environment. The most intrusive strategy is to remove the child from the group either socially by having the child do another activity or physically and socially by having the child do something different outside of the classroom environment. Strategies that adapt activities, materials, and instruction or establish learning environments where children work together cooperatively can be very effective ways of improving the classroom environment, generally, and of promoting participation of children in classroom activities and routines.

The needs of children with specific disabilities, for example, children who cannot see or hear well or children who do not learn as quickly as other children, can be overwhelming when adults have not had experiences with these types of learning needs. In essence, these children contribute diversity in abilities to the classroom environment so that teachers may be required to work with a broader range of diversity than might be present if children with disabilities were not included. Diversity enriches the classroom culture and the lives of all children. Fortunately, activities can be modified easily to emphasize the strengths of children's learning. For example, children with visual disabilities can learn to match with cues in order to put toys and materials away or toys and materials can be kept in specific locations so that a child knows where to find things and learns that things are

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always in the same places. A material called Dycem (or Rubbermaid shelving mats) can be used to hold objects in place for children with difficulty grasping or using both hands together. Breaking an activity or task down into smaller parts and then having a child complete one part at a time makes learning less complicated for children with intellectual challenges.

Children with disabilities or significant delays in development often receive services through early intervention or preschool special education programs. These service providers may include physical and occupational therapists, speech and language pathologists, or special education teachers (early intervention teachers). These specialists can be a resource to child care providers and can help design adaptations and accommodations to promote the child's participation and to facilitate their learning. Child care staff should use these specialists as a resource for ways of adapting the classroom environment and for promoting children's participation in specific activities and routines.

### **Planning for Successful Learning For ALL Children**

Some children may learn new abilities with the addition of specialized techniques that are directed toward helping them learn a particular skill(s) or ability. For example, a child who has difficulty understanding language may be helped to develop better language understanding abilities when specific activities are used to provide sequenced experiences in understanding more complex language. A child with visual impairment may learn to use residual vision more effectively through specific exercises to improve visual discrimination. A child with autism may learn to interact socially with other children more effectively when specific social competence interventions are used or may learn particular skills under very structured and adult-directed learning situations. These special techniques and strategies are the knowledge base of specialists who can assist early

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childhood staff to learn and use these techniques with particular children within the context of the activities and routines that occur normally in the child care setting. Adaptations make it possible for children to participate and learn. Also, use of special techniques that are embedded into typical activities and routines may be needed so that all children have opportunities to learn and develop to their full potentials.

All child caregivers want children to do well. Sometimes, some children do not do well unless the classroom schedule, curriculum or activities accommodate their abilities and inabilities, likes/dislikes, or general preferences. Being able to individualize interactions and teaching for all children begins with planning. The strengths and concerns for individual children will be accommodated in how child care staff organize the schedule, curriculum, and activities. By designing a schedule, curriculum, and activities ahead of time, child care staff can plan for ways in which activities can build on children's strengths and interests as well as provide a context in which individual concerns and needs may be addressed.

In classrooms and programs, there are activities and routines that go well as well as those that don't go so well. Often, simple adaptations can create a better "fit" between children's needs and the requirements of the activities. Using a bell to sound a "warning" for the end of free play is an example of an adaptation that can help children learn a routine of putting their toys away. Giving a child who wanders around and doesn't get to the next activity after freeplay, a card that has a picture of the book corner on it can help that individual child know that the next activity is story time. These are simple strategies for keeping groups of children and individual children organized so that activities and routines go well for all children.

Instructional plans can be written for children with special learning needs that help teachers plan ahead for the ways in which children's needs may be best accommodated. General (or generic) instructional plans help teachers plan for children across different activities and help them consider what might be

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done when the other children are doing things in particular ways. For example, some children with disabilities such as cerebral palsy or other physical disabilities may be unable to sit, crawl, stand, or walk in the ways that typical children do. A generic instruction plan helps teachers plan for how children will be positioned for activities so that they can participate with other children.

An individual matrix provides a way for making sure that children have opportunities for learning the particular things they need to learn during classroom activities. Children with special needs who receive early intervention services have either an Individual Family Service Plan (IFSP) or an Individual Education Plan (IEP) that outlines specific goals and objectives that will be accomplished. These goals as well as other goals that child care staff may have for a child can be written on an matrix in order to plan opportunities when children can learn these specific skills during normal classroom activities. Individualized teaching strategies may be necessary in order to support children's learning.

## **Helping Children Learn New Skills Successfully**

Children learn new information in a variety of ways. A lot of information is learned "incidentally" as children watch, listen, and experiment on their own. The environment provides children with cues about what to do. These are called natural cues. For example, when a teacher puts out cups and juice, the cups and the juice are natural cues for drinking. Most children will take a drink under these circumstances, if they are thirsty, but some children may need more instruction or support to participate in this activity.

### **Cues**

A teacher might have to draw the child's attention to the cup (for example, by tapping the cup on the table), or tell the child "Here's

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juice" or "Drink the juice", or may actually have to help the child reach and get the cup and bring it to the mouth to drink. Any of these teaching strategies are designed to get the child to drink, including perhaps actually teaching the child how to drink from a cup. These are called contrived cues because they do not occur naturally and are used specifically to teach one or more children to do something that is expected. Contrived cues vary in level of intensity from placing an object in a particular place to drawing a child's attention in some way to the expectations, to giving specific directions, to tapping a child to provide a cue about what is expected, or to actually physically guiding a child to do the activity.

Teaching strategies may be direct (contrived) or indirect (natural). Telling a child to take a drink is an example of a direct strategy as is physically moving a child's hand to help her hold the cup. Asking a child a question such as "are you thirsty?" or asking a group of children "who is ready for snack time?" are examples of indirect strategies. These strategies don't tell children exactly what to do (drink; go to the snack table) but cue them as to what is expected. When using indirect strategies, it is important to recognize that choices may also be implied. A child has the option of answering any "yes/no" question with "no." It is not a good idea to offer children cues in the forms of questions where teachers will not be happy with "no" responses. For example, it might be better to say "snack is ready" than "who is ready for snack time?" or "here's juice" instead of "are you thirsty?" if you are not sure that the children are ready for snack or are thirsty.

**Consequences**

Providing children with rewards is a powerful teaching strategy. Rewards can be both natural and contrived. If there is a child who never drinks at school, a teacher might find out from a parent that the child really likes apple juice and then might make sure that this juice is what is given to the child. In this case, the juice is a natural reinforcer or reward for drinking. Contrived rewards occur when teachers provide children with special

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attention, a special food treat, participation in an activity, or some prize or special toy because children have done something appropriate or not necessarily desirable from the child's perspective. For example, making a child the one to hang something up, pour the juice, or do something special is an example of a contrived reward. Rewards can be given continuously or randomly. Continuous rewards may lead to faster learning but children may tire of the reward and teachers may have difficulty being consistent in giving the reward each time a child does something. Random rewards are not given every time but are given irregularly. Whether continuous or random rewards are used, it is important to be consistent. Rewards are a consequence for children's behavior. A child who drinks the apple juice, something that the child likes, is getting a positive consequence for her drinking.

Adult attention can be a powerful reward or consequence for some children. Adults who yell at children or who pay a lot of attention to them when children are misbehaving or not doing something an adult wants them to do may actually inadvertently increase the child's inappropriate behavior because they are providing the child with a "reward" – their attention.

### **Using Cues and Consequences as Teaching Strategies.**

There are two ways to use cues and consequences. In the teach down sequence, teachers start with natural cues and increase the amount of assistance needed until the child is able to perform. Teachers can teach up, using physical assistance, then demonstration (or modeling), gestures, directions, and natural cues. This is a sequence where more intrusive cues (physical assistance) are faded to less intrusive cues (directions) and eventually to natural cues. For example, in teaching a child to cut with scissors, a teacher might place her hands around the child's, guiding the child to cut (physical assistance) and then might simply sit next to the child and demonstrate or model cutting (demonstration) until finally, just

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the scissors on the table and the need to cut something function as cues for cutting. With very young children, starting with physical assistance or demonstration is often more helpful than verbal directions. Young children, in particular, may not yet have sophisticated enough language skills to be able to follow directions as a means of learning. Physical assistance or demonstration may be more effective.

## **Individualizing Participation and Learning for Children with Specific Developmental or Health Concerns or with Disabilities**

The following section provides information about children with a variety of types of developmental or health concerns or disabilities and includes suggestions for ways to meet general learning needs. Some types of developmental concerns occur relatively frequently such as delayed speech and language abilities or behavior concerns. Others occur very infrequently such as children with severe and multiple disabilities or with vision or hearing impairments.

### **Children with Speech and Language Concerns**

Many children may show delays in speech and language abilities. Some of these delays are not long-lasting, in other words, children will "outgrow" their delays as they get older. There is a wide range of "normal" in terms of what ages children first speak, what they say, and how rapidly they learn to use language to communicate their needs, thoughts, ideas, and emotions. Children may have delays in understanding language (receptive language) or in speaking and communicating (expressive language). Speaking delays are not thought to be a major issue when children have typical abilities to understand language. In other words, when children understand what is

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said to them but have difficulty replying, do not speak as frequently as other children, or use less complicated vocabulary or language structures than what would be expected, they may well be demonstrating delays that will resolve without intervention (or with minimal intervention) over time. Many children who are being raised in bilingual environments may also demonstrate "temporary" delays in, for example English, when Spanish is the primary language used at home. Greater concerns are appropriate when children do not use communication (gestures, facial expressions, or vocalizations) within a social context, when children do not seem to understand what is said to them, or when children make few attempts to communicate basic needs or wants.

Children with significant communication disorders may receive services from a speech and language pathologist who will be responsible for arranging learning activities so that children have opportunities to communicate and receive whatever assistance is needed for them to use their communication skills. Many children's communication improves dramatically when they are in inclusive classrooms because there are many typically-speaking children who provide models for how the child should speak. Children may not have speech and language disorders, alone, but these disorders may co-occur as part of a broader disability such as deafness, deaf/blindness, physical disabilities, autism/pervasive developmental disorder, or intellectual disability (mental retardation). In these instances, speech and language pathologists can help design specific adaptations such as expressive communication systems and can assist teachers with the most effective ways to communicate with children. Even when children receive therapy that is separate from their everyday lives, such as individual speech therapy sessions, the ways in which they are helped to communicate throughout the day is critical. Everyday circumstances provide the "need" to communicate with others or the context in which speech and language is used functionally.

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**Children with Epilepsy or Other Health Conditions**

Most children with epilepsy have their seizures controlled by medication. Teachers may never see a child have a seizure or even be aware that the child has epilepsy unless medications are administered at the center. For other children, seizure activity may be difficult to control and very small seizures, usually called petit mal seizures, may be difficult to observe. A child may look "blank" for seconds or may seem momentarily not to be paying attention to what is going on. Sometimes it is important for teachers to keep records (along with the child's parents and other caregivers) about observations of seizures. This is especially important when medication may need to be changed or when a child has not yet been started on drug therapy. Child care staff should know what a child's seizure may look like and what to do if a seizure would occur. The child's parent(s) or a public health nurse can show teachers what to do if a seizure were to occur.

Children may have epilepsy or seizures without any other developmental problem. However, seizures are likely to occur, also, in combination with other disabilities such as cerebral palsy, multiple disabilities, or some forms of mental retardation. Medication is given to control or reduce seizures when children have seizures in combination with other disabilities. While seizures are controlled through medication for most children, some children's seizures may not be fully controlled and the child may have seizures periodically even with medication. Very young children (such as infants) may have seizures that are eventually outgrown (or that go away with age), but most children with seizure disorders will have them throughout their lives. Seizure disorders may be present, also, when children have no major disability such as cerebral palsy or spina bifida but when they have special health care needs. These may be children with severe respiratory problems, or heart problems, or other medical conditions that are managed through equipment,

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devices, and medication. No matter whether children actually have seizures frequently or have them alone or in combination with other issues, the most important thing is for teachers to be careful observers of children and to be comfortable with what to do if a child were to have a seizure while at child care.

**Children with Down Syndrome**

Perhaps one of the most widely known and recognized disorders is Down syndrome. Children with this disorder are generally easily recognizable because of the physical characteristics associated with the condition. In recent years, people with Down syndrome have been movie and TV actors and actresses, catalogue models, and authors as well as people who are highly visible because of their employment in community settings such as stores, restaurants, and gas stations. Early intervention, providing early education and intervention for children when they are infants has been effective in helping children with Down syndrome grow and develop at rates comparable to developmental rates of typically developing children. The largest developmental challenges for children with Down syndrome are speech and problem-solving (or cognitive or intellectual growth). Being around typically developing children provides children with Down syndrome with peers who constantly demonstrate appropriate speech, social, and intellectual abilities. Instructional (or intervention) strategies that break tasks into small attainable steps and provide children with concrete learning experiences are effective in helping children with Down syndrome fully participate in child care activities and routines.

**Children with Concerns About Social or Emotional Development**

Caregivers have become increasingly concerned about the numbers of young children with difficulties relating to other children or who seem to be depressed or fearful, overly violent

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in their play or who just don't seem to be happy and adjusted. Some of these children are viewed as immature. They may be violent or aggressive with toys, to other children, or themselves. Whatever types of behavior children demonstrate, adults often view their behavior as significantly different from other children. Emotional disturbance is a broad category of disability that may include diagnosed conditions such as hyperactivity, relational disorders, autism or pervasive developmental disorder, childhood schizophrenia (not generally observed in very young children), and other medically-labeled conditions. Or, children may simply get labeled by those around them as "fearful", "violent", "aggressive", "self injurious", "nervous", or other labels.

Positive interactions between adults and children and encouraging all children to interact in positive, respectful ways is important. Many children with emotional disturbance (or immaturity) do not seem to have positive concepts of themselves and their abilities and strengths. Helping them develop positive views of themselves and good social relationships with other children can be accomplished through strategies that both manage any "deviant" behavior such as repetitive self-injurious actions while promoting interactions and acceptance among children. When children demonstrate violent behavior, strategies such as conflict resolution can help them learn more effective ways of managing and controlling anger. Opportunities to express feelings in socially acceptable ways is another strategy that is helpful with some children. For example, setting up an activity where children throw or kick balls against a wall is a more appropriate activity than kicking or hitting out at other children. Working with children with emotional disturbance can be challenging, especially when adults become frustrated and begin to assign intentionality or meaning to the child's actions ("he hits himself on purpose;" "he sucks on all the toys even though he is four years old; he must need the oral stimulation of sucking") but, as with children with other types of disabilities and delays, adaptations can be helpful in promoting children's participation in routines and activities and providing

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them with successful experiences.

### **Children with Autism, Pervasive Developmental Disorder (PDD), Autism Spectrum Disorder (ASD)**

A growing number of children are being diagnosed with this disorder at increasingly earlier ages. A growing number of children are being diagnosed with this disorder at increasingly earlier ages. Children with autistic disorder (i.e., autism) or with PDD have wide ranging types of behavior. People with autism have been represented widely in the media, for example in the movie *Rainman*, but all people with autism do not act alike. Social communication disorders include children with no verbal spoken language (or attempt to communicate through gestures or other means) as well as children who speak but whose speech may be characterized by repetition (often labeled echolalia), unusual inflection patterns, or difficulties in initiating or sustaining conversations with other people when children are able to speak. In general, many children with autism, even those who have speech, may speak but not use speech to really communicate meaning. They may be able to repeat a lot of language and may do so immediately after hearing the language or many days later. Children who have no spoken language often are able to communicate using picture boards, communication cards, or sign language.

Social interaction disorders may include marked impairment in the use of behavior such as eye gaze, facial expressions, or gestures that are used by typical children to initiate and sustain social interaction with others. Other children may demonstrate some of these nonverbal social behavior patterns but may not develop peer relationships or may not seek out ways of sharing enjoyment, interests, or achievements with others.

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Characteristically, the limitations in social communication and interaction may be "replaced" with other activities in which a child shows abnormal interest. This interest is viewed as abnormal because a child's focus may be quite limited in focus (plays only with the wheels on a particular truck or one particular piece of yarn) or intensity (plays with the wheels on the truck for hours and hours, days and days). Or, a child may demand that particular routines and rituals are followed and may be upset if routines are changed or altered in even the smallest ways (may only eat certain foods or take a bath following a specific routine). Changing a ritual may result in a temper tantrum. Many children perform highly visible stereotypic or repetitive motor mannerisms such as flapping their hands, rocking, toe-walking, twirling their bodies and sometimes more dangerous behaviors such as head banging or other types of behavior that cause self injury.

PDD syndrome is a psychiatric diagnosis but the causes of the condition are believed to be neurological. Because the neurological impairment is not understood, diagnosis is based on clinical findings and on differentiating PDD syndromes from other types of diagnoses. However, children with PDD syndromes may have other types of conditions (or diagnoses) in addition to one of the five types of PDD syndrome (i.e., Asperger's, autistic disorder, Rett's, CDD, or PDD-NOS). The most common associated disorders are mental retardation, seizures, or Attention Deficit Hyperactive Disorder (ADHD) but these do not always accompany a PDD diagnosis. Children may also have some of the same conditions that all children may have such as health problems or vision and hearing disorders.

## **Children with Deafness and Hearing Loss**

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As with other disabilities, deafness and hearing loss can vary from children whose hearing loss is so severe that they are unable to process language even when hearing has been corrected through wearing a hearing aid to children with temporary and fluctuating hearing loss that may affect their abilities to learn language or speak clearly. There are two primary ways of educating children with severe hearing impairment (or deafness). One is an oral approach where children are taught to lip read, attend and discriminate whatever sound they do hear, and speak. A second approach is to teach children to "speak" using some form of sign language where they speak with their hands. A third way of educating children combines both approaches so that children learn to sign and speak at the same time. No one way seems to be best for all children with hearing impairment. Rather, there are proponents for the use of all three methods although some methods appear to work better at certain time periods. For example, an oral approach seems to be particularly helpful when children are diagnosed as infants, receive amplification, and special instruction or training from an early age. The effectiveness of each method also seems to be related to the extent of a child's hearing loss. Some educators of children with hearing impairment, for example, advocate sign (or total communication) when children have severe hearing loss.

More than likely, a child with hearing impairment who attends a child care setting will be receiving special instruction or speech and language therapy to assist the child in learning to communicate -- whether through speech only, sign only, or speech and sign together. These specialists can assist child care staff to learn signs so that these signs can be taught to all children in order to communicate with the child who is hearing impaired. Simple sign is easily acquired by children and adults (although being competent in "speaking" sign language is really comparable to being able to speak a language in addition to a person's native language). Specialists can also help child care staff learn to use adaptations, such as picture boards, to

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communicate with a child or to allow a child to express him- or herself in specific situations. The most important thing to realize with young children who have significant hearing loss is that they will require special instruction to learn to understand and use language. This instruction will be provided by special teachers of the hearing impaired but, most of the time, will be provided by child care staff and family members in their daily interactions with children.

Many young children and children with disabilities are prone to middle ear infection during the early childhood years. Persistent and recurring ear infections which are not treated medically or through surgical insertion of tubes, can influence what a child hears. Since all young children are learning language during infancy, toddlerhood, and early preschool years, these ear infections can make a child hear sounds differently than they actually sound and, thus, influence how a child speaks. Many children with recurrent ear infections speak unintelligibly when first learning to talk. For example, they may drop off final consonants (say, ca instead of cat) on some words because when they hear the words themselves, they don't hear the final consonant. When young children regularly receive well-child checkups, physicians are careful to monitor for middle ear infections and when children receive regular medical care, physicians know when ear infections are occurring repetitively. Some young children, however, do not receive regular medical care from the same physician (or physician group), and ear infections may be undetected and uncorrected.

### **Children with Vision Impairments**

Like other disabilities, vision impairments can range from very mild situations that are corrected through glasses to conditions that result in total blindness. Obviously, little to nothing needs to be done to involve children whose vision problems are fully corrected through glasses. For other children, simple

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adaptations such as "books on tape" or large print materials may be sufficient. Many of these materials are available through local resource centers for people with visual impairments or through special education resource centers. However, when children have significant visual disabilities, special adaptations such as braille or instruction, such as mobility training, may be needed in order for children to learn literacy skills and to get around the environment. Computers and software that present information verbally (rather than only through pictures or print) can be helpful when children have low vision or are legally blind. Child care staff can make many simple adaptations to assist children whose vision is impaired. Keeping materials in the same location and marking them with a sensory "aid" such as an object that children can feel helps children find and use materials. Toys with high auditory output or with concrete features are also helpful. Arranging the classroom environment so that things stay in the same places makes it easier for children to get around the room (or center) independently. Children benefit from multi-sensory presentation of information so making sure that materials have a lot of tactile (feeling) and auditory (hearing) input is useful.

### **Children with Cerebral Palsy and Other Motor Disorders**

Neurological motor disorders, such as cerebral palsy, can range from mild dysfunction (a child may not be as coordinated as children of similar ages) to severe disorders where children may be unable to walk, talk, communicate, or perform other tasks due to the inability to use their bodies motorically to carry out these tasks. Young children with severe motor dysfunction are likely to demonstrate severe developmental delays, but these delays are not comparable to mental retardation or intellectual disability. Many of these children learn to communicate verbally or through alternative devices such as expressive communication systems when they become three to four years

### Notes:

old. When communication is possible, adults can begin to understand what children know and understand about their environment. Prior to that time, difficulties with movement may prevent a child from doing age appropriate things like eating and drinking, playing with toys, manipulating materials within activities, or getting around independently.

Accommodations and adaptations are critical to helping children with motor disabilities participate in activities and routines within a child care setting. Special devices can help children sit, stand, and walk. Adapted toys allow them to play independently and with other children. Special devices like spoons, cups, utensil holders, rubber matting, slant boards or easels can help children be independent in caring for themselves and in participating in learning activities. The physical and occupational therapists who may be working with children are a good source of information about the types of equipment and devices available. Parents also have good ideas about simple ways of helping their children succeed. Books and catalogues are available, also, that are sources of ideas as are local resources such as Lekotek and other materials resource centers.

Many children with severe forms of motor disabilities may never learn to do the motor skills that other children learn and do naturally. Some children may never learn to dress and undress themselves or get on and off a toilet without assistance or to walk. Through the use of adaptations and therapy, children can learn to get around independently (for example, by using equipment such as motorized wheelchairs). By working collaboratively with children who are competent in motor skills, children with cerebral palsy or other motor disorders can complete projects and contribute their unique strengths and talents.

### **Children with Traumatic Brain Injury**

**Notes:**

Traumatic brain injury (TBI) results from accidents where an external physical force causes damage to the brain. Some children with TBI may have physical disabilities that makes it difficult for them to walk or to perform other motor skills. Others may be able to move but do so in an uncoordinated way. These physical disabilities may be accompanied by difficulties with judgement, thinking and problem solving, perception, reasoning and abstract thinking, or other abilities that are a result of brain functioning and by special health care needs involving infection, breathing, and eating. Brain injury is more common among older than younger children but can result from situations such as child abuse or falling accidents when children are young.

Recovery from brain injury takes place over several years. As a child recovers, things that were not possible immediately after the accident or injury may return. This is referred to as spontaneous recovery. Many children with brain injury receive a lot of physical or occupational therapy, speech therapy, and other services in order to maximize the spontaneous recovery that is occurring. Therapy and other rehabilitation services are provided, also, to teach children skills that may have been lost due to the injury and to help them learn to do things in potentially different ways. For example, a child who was able to eat independently before an injury may need to relearn how to eat and may do so with special utensils or other modifications. Child care staff who are caring for children with TBI should be working closely with the child's rehabilitation team in order to maximize children's opportunities for recovery and for function. These professionals can provide helpful ways of teaching to individual children's strengths as well as examples of adaptations that help children manage problem-solving, reasoning, and other cognitive functions. Adaptations that are appropriate for a disability category, such as those that might be used when a child has a physical disability are useful with children with TBI who have motor impairment as a result of their injury.

**Notes:****Children with Spina Bifida**

Spina Bifida is a condition that results in paralysis of the muscles below a specific point on the spinal cord. Depending on the nature and extent of the lesion on the spinal cord, children may also have either no or incomplete sensation below the level of the lesion. Some children also have a related condition called hydrocephalus where spinal fluid is not able to circulate properly and accumulates in the brain, often causing pressure on the brain itself. Hydrocephalus can be corrected by placing a plastic tube inside the brain that drains the fluid from the brain to some other place in the body such as the heart or the stomach area. There is no surgical correction at this point in time for the paralysis that results from the spinal cord injury.

Spina Bifida does not occur very frequently. The type of motor disability that results depends on where the lesion is located on the spinal cord. Some children have paralysis from the nipple line down to their feet but other children may have only some paralysis in the lower legs and feet. If the lesion occurs above the spot in the spinal cord where the nerves go to bowel or bowel and bladder, children will have no sensation of needing to void and, as they get older, special strategies will be taught to them to help manage their bowel and bladder function independently. When they are young children, they will need to be changed (as if they were not toilet trained). Hydrocephalus may result in some damage to the brain which may result in children having learning difficulties or with paying attention or with communication. Most children with Spina Bifida will learn to walk with crutches or walkers and most will wear braces (or orthoses) of some type. When working with children, it is important to remember that they may not be able to feel anything in their legs and may not feel pain or other sensations in their legs. As with other children with motor disabilities, children will need assistance from a physical therapist in order to learn

**Notes:**

walking skills or how to manage their braces or get sufficient exercise or strengthening of muscles. Adaptations and environmental accommodations -- particularly adaptive positioning equipment and walking aids -- are very helpful in promoting participation in learning activities and routines.

Children with Spina Bifida, cerebral palsy, brain injury, or other types of motor challenges may need to be moved by adults. Using proper lifting and handling procedures, providing children choices, and other considerations are important for all children with motor problems (no matter what the diagnosis or origin of the motor disability may be).

### **Children with Mental Retardation or Severe/Multiple Disabilities**

Making accommodations and adaptations for children who are blind, deaf, or physically disabled (but normally intelligent) sometimes seems easier than accommodating the needs of children who have difficulty learning or relating to other people. The incidence of disabilities such as mental retardation (or intellectual disability) or delayed development (in one or more areas of development) is higher than the occurrence of disabilities such as physical disability. In fact, the highest incidences of disability in young children are delayed overall development (with special learning needs), speech and language delays, and pervasive developmental disorder (PDD/Autism Spectrum) -- all of which result in difficulties with learning and relating to other people. As children move into school age, Attention Deficit Disorder (ADD/ADHD) becomes the most common disability among children.

Both mental retardation and severe disabilities are related to difficulties with learning and generally with understanding and using speech and language. When children have severe/multiple disabilities, they may also have special health

### Notes:

care needs or disabilities such as deafness, blindness, or motor disabilities which will need to be considered when designing adaptations and teaching strategies. The numbers of children with severe or multiple disabilities are small. Curricular modifications and adaptations are necessary to help children learn. Depending on the extent of intellectual disability, children may be learning what are called functional skills -- skills that are important and essential to their future as adults. This means that children may not, for example, play with blocks like other children but will learn to eat and drink independently. Or, a child with a severe physical disability may not ride a tricycle around the play yard but will learn, instead, to move a wheelchair independently.

Mental retardation covers a wide range of abilities. Some children learn the same things that other children do but learn at slower rates or need specific types of instruction in order to be able to learn. Other children may never learn the same things that typical children know but will be able to learn the types of skills necessary to function in life. A child may be able to learn to count and recognize and use money (functional math skills) but may not be able to learn calculus or algebra as a high school student. For many children with mental retardation, learning is more concrete than necessary for children with average levels of intelligence. For example, some children can "discover" the relationships among objects -- some are bigger, some are smaller -- by manipulating materials and figuring out sizes through manipulation. For children with mental retardation, these relationships may have to be taught using teaching methods that point out the differences sufficiently so that children can grasp concepts such as size.

### Notes:

### Summary

Four key areas are covered during this session:

- T the relevance (or irrelevance) of labels as descriptions or representations of individuals;
- T how children with special learning needs can successfully learn and be included in caregiving activities and routines;
- T how to accommodate children with particular types of learning needs by individualizing curriculum, classroom activities and routines, and teaching strategies;
- T descriptions of children with various developmental concerns, delays, or disabilities (provided mainly as reference material for participants).

# Including All Children Everywhere

	<b>Blocks</b>	<b>Math and Manipulatives</b>	<b>Dramatic Play</b>
<b>Children With Visual Challenges</b>	Give the child a small number of blocks. Trace each shape on cardboard, cut it out, and tape it to the shelf where it is stored to encourage independence.	Describe objects to reinforce sensory information: "These are all round buttons. Here is the biggest one. Can you find one that feels a little smaller?"	Let the child examine play props with varied textures and try to guess their identities. Discuss each object's features.
<b>Children With Hearing/Speech Challenges</b>	Make sure that the child understands the rules. Act them out and post pictures as reminders.	Describe what the child is doing, using words that identify math relationships (bigger, smaller, half, greater, less).	Find nonverbal roles the child can assume, such as sleeping baby, animal in the zoo, or mail sorter in the post office. Reinforce lipreading.
<b>Children With Physical Challenges</b>	Be sure that the child is well positioned so his hands are free to manipulate and play with blocks.	Work with the child's therapist to choose appropriate materials, such as a magnetic board with letters and numbers. Adapt objects so they are easily grasped.	Use furniture that is heavy and stable to give the child something to lean on. Leave open space, and avoid area rugs. Encourage the child to interact with nondisabled children.
<b>Children With Cognitive/Intellectual Challenges</b>	Give the child a small number of blocks to start with - and lots of modeling and encouragement. Show the child what to do, and acknowledge all efforts.	Give the child plenty of time to experiment with the shape, size, and basic characteristics of materials.	When the group is involved in a situation above the child's level, act as a play partner to the child. Draw the child's attention to peers by using props in imaginative ways.
<b>Children With Social/Emotional Challenges</b>	Encourage cooperative play through group projects. Help stem aggressiveness by reviewing rules for appropriate behavior often.	Invite the child to join in a group activity, but don't force participation. Describe the activity and give the child a role to play.	Begin as the child's play partner, gradually inviting one or two other children to join. Suggest plot ideas if needed.

# Including All Children Everywhere

## Literacy and Drawing

## Messy Play

### Children With Visual Challenges

Share books with embossed or textured surfaces. After listening to a story, offer the child precut shapes of the characters and the chance to trace them.

Explain how tools are used as the child handles them. As you model, actions such as pouring sand into a funnel, let the child feel your hands, the tools, and the sand.

### Children With Hearing/ Speech Challenges

Use signs, gestures, and facial expressions to clarify your words. Set up an area where the child can listen to a cassette player set at a higher volume.

Make sand and water play available: these activities can be very satisfying for children with hearing difficulties.

### Children With Physical Challenges

Remove the paper from crayons. (The warmth of a child's hand will help her maintain a firmer grip.) Stabilize paper by taping it down. Encourage the child to finger paint.

Encourage the child to exercise the small muscles in her hands. Consult with the child's physical therapist for guidance.

### Children With Cognitive/ Intellectual Challenges

Before you share a story with the group, read it to the child alone. Stories with rhymes, rhythm, and/or repetition work best. Read favorite stories often.

Teach vocabulary and concepts as children play. Model new ways of using materials and provide tools that relate to concepts the child already knows.

### Children With Social/Emotional Challenges

Keep stories short. Encourage the use of storytelling and drawing to communicate feelings.

Offer a limited number of materials. Encourage cooperative play and sharing.

# Including All Children Everywhere

## Music and Movement

## Science

**Children  
With Visual  
Challenges**

Offer rhythm instruments and encourage singing. Use finger plays to help the child learn to associate pictures with words.

Encourage the child to use senses other than sight: to hold objects, to smell and taste substances, and to listen for sounds.

**Children With  
Hearing/  
Speech  
Challenges**

Encourage the child to respond to beats and rhythms by feeling the vibrations from recorded music through wooden floors and furniture.

Use visual aids and demonstrations to explain and discuss projects. During exploratory activities, ask the child to check understanding.

**Children With  
Physical  
Challenges**

Intersperse lively music with quiet, calming music to help a child who might lose muscle control if over-stimulated. Encourage the child to move her body in safe ways.

Adapt tools and materials so the child can explore and learn independently.

**Children With  
Cognitive/  
Intellectual  
Challenges**

Build extra time into activities. Offer direct assistance if needed, and give precise instructions for using each instrument or material.

Let the child work at her comfort level while encouraging her to experiment and discover new possibilities.

**Children With  
Social/Emotional  
Challenges**

Divide music activities into short segments. Encourage the child to express emotions.

Provide plenty of materials and space to work. Keep activities short. Encourage exploring in group projects.

Marguace, M. (1996). Including all children everywhere. Scholastic Early Childhood Today, November/December, 24-25.

# MENTAL RETARDATION

## DEFINITION:

- C significantly sub-average general intellectual functioning (usually score below 70 on intelligence tests)
- C with deficits in adaptive behavior (difficulties in learning, communication, social, academic, vocational, and independent living skills)
- C manifested during the developmental period (usually onset before age 22)
- C adversely affects child's educational performance

## BIOLOGICAL CAUSES:

Chromosome abnormalities, asphyxia, blood incompatibilities, maternal infections, and certain drugs

## INCIDENCE:

1% of the general population and 1.7% of the total school enrollment

## CHARACTERISTICS:

- C like other people but develop at a slower rate
- C may have difficulties in attention, perception, or memory
- C depending on the severity people may develop differently

## TEACHING CONSIDERATIONS:

- C use concrete materials, functional, relevant, and age appropriate
- C present information in small, sequential steps, and review often
- C provide prompts and consistent feedback
- C use inclusion
- C teach skills outside of the child care curricula

# SEVERE AND/OR MULTIPLE DISABILITIES

## DEFINITION:

Generally refers to people who have severe to profound mental retardation. People generally require ongoing support in more than one major life activity to fully participate. People with severe disabilities may have additional challenges including movement, sensory, and behavior.

## INCIDENCE:

About .2% of the general school-age population

## CHARACTERISTICS:

- Ⓒ Challenges in communication, Mobility, and Generalization and Maintenance of Skills
- Ⓒ Need for support in major live activities (home, leisure, community, and work)

## TEACHING CONSIDERATIONS:

- Ⓒ Children may receive multiple services
- Ⓒ Focus is on language, social, and functional skills
- Ⓒ Children may have specialized equipment, medication, and diets
- Ⓒ Inclusion with appropriate support and curricular modifications
- Ⓒ Team approaches

# Rating Activities

Name \_\_\_\_\_

Theme \_\_\_\_\_

Child Care Center \_\_\_\_\_

Center Area \_\_\_\_\_

Age of Children \_\_\_\_\_

How many activities did your group review? \_\_\_\_\_

	How many activities that you reviewed received the following ratings for the child?
3 - Really great	
2 - OK	
1 - Not Good	
Total Number of Activities	

What was the best activity for the child? \_\_\_\_\_

Why did you like the activity? \_\_\_\_\_

\_\_\_\_\_

What kinds of things would the activity teach the child? \_\_\_\_\_

\_\_\_\_\_

What kinds of adaptations would you need for the child? \_\_\_\_\_

\_\_\_\_\_

# SPEECH AND LANGUAGE DISORDERS

## DEFINITION:

Problems in communication and oral motor functioning

## CAUSES:

Hearing loss, neurological disorders, brain injury, mental retardation, drug abuse, physical impairments such as cleft lip or palate, and vocal abuse or misuse, and unknown causes

## INCIDENCE:

Estimated to affect one out of every ten people in the United States

## CHARACTERISTICS:

- C delays in receptive or expressive language including challenges with understanding context for words, proper use of words and their meanings, grammatical patterns, vocabulary, and following directions
- C challenges in producing speech sounds or with voice quality
- C interruption in the flow or rhythm of speech
- C challenges with the way sounds are formed, or the pitch and volume of the voice

## TEACHING CONSIDERATIONS:

- C early identification and intervention,
- C inclusion,
- C step-by-step teaching,
- C feedback,
- C home and child care considerations

# CEREBRAL PALSY

## DEFINITION:

Cerebral palsy is caused by damage to the brain and usually occurs before, during, or shortly after birth. It is a disorder of movement and posture and is not progressive or communicable.

## BIOLOGICAL CAUSES:

Illness during pregnancy, premature delivery, or lack of oxygen supply

## INCIDENCE:

3,000 babies are born each year and another 500 acquire it early in life

## CHARACTERISTICS:

- C children have challenges in controlling their motor functioning
- C muscle tone can fluctuate, low, or high
- C children may have difficulties walking
- C other issues can include seizures, sensory impairments, speech disorders, and mental retardation

## TEACHING CONSIDERATIONS:

- C early identification and intervention
- C may need some personal assistance
- C technology
- C adaptive equipment

# EPILEPSY

## DEFINITION:

Epilepsy is a physical condition that occurs when there is a brief sudden change in how the brain works. A person's consciousness, movement, or actions may be altered for a short time. A seizure does not mean epilepsy (febrile, alcohol, drug withdrawal, imbalances).

## INCIDENCE:

2 million Americans (less than 1%) - 50% of people with epilepsy are children and adolescents

## CHARACTERISTICS:

- C blackouts or periods of confused memory
- C episodes of staring or unexplained periods of unresponsiveness
- C involuntary movements of arms and legs
- C fainting spells may have incontinence or periods of fatigue
- C odd sounds, distorted perceptions, episodic feelings of unexplained fear
- C repetitive behaviors (partial)

## TEACHING CONSIDERATIONS:

- C child may be missing parts of what the teacher is saying
- C documentation of episodes for parent and physician
- C know the effects of medications and what to do if a seizure occurs
- C social aspects

# DOWN SYNDROME

## DEFINITION:

Down syndrome is the most common and readily identifiable chromosomal condition associated with mental retardation. An accident in cell development occurs resulting in 47 rather than 46 chromosomes. Most of the time it is diagnosed through chromosome testing shortly after birth.

## INCIDENCE:

About 1 in every 800 to 1000 live births. The incidence is higher in births to women over 35

## CHARACTERISTICS:

- physical - low muscle tone, epicanthal folds, hyperflexibility, short broad hands with a crease across the palm of one or both hands, broad feet with short toes, flat bridge of the nose, short low set ears, short neck, small head, small oral cavity, small stature
- health - lower resistance to infection, heart defects, sensory impairments, atlantoaxial instability (should be examined by a physician to determine if child should be restricted from activities placing stress on the neck), weight gain

## TEACHING CONSIDERATIONS:

- C early identification and intervention
- C place few limitations on child's capabilities
- C emphasize concrete rather than abstract
- C teach step by step

# Autism Spectrum Disorder

## DEFINITION:

- Must demonstrate 6 out of 12 characteristics listed in the American Psychiatric Association DSM-IV; these relate to social communication, social interaction, & stereotypic behavior
- May have mental retardation, seizures, sensory integrative dysfunction, or other associated disorders
- Need assistance in developing relationships with peers, in language & social communication, & in play skills

## INCIDENCE:

Affects about .4% of the school-aged population.

## CHARACTERISTICS:

- Social communication disorders
- Social interaction disorders
- Stereotypic behavior

## TEACHING CONSIDERATIONS:

### Modify the Environment

Some children with autism are oversensitive to sounds or lights. Reduce these as much as possible.

Use pictures or objects to enhance communication.

### Build on Children's Strengths

Avoid long series of verbal directions

Emphasize children's talents -- like drawing or computers

Use fixations as part of teaching

Typing is usually easier than writing -- encourage children to write via computer or other means (such as putting magnetic letters or letter blocks together to form words)

# EMOTIONAL DISTURBANCE

## DEFINITION:

A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects educational performance--(A) inability to learn that can not be explained by intellectual, sensory, or health factors; (B) inability to build or maintain satisfactory interpersonal relationships with peers and teachers; C ) inappropriate types of behavior or feelings under normal circumstances; (D) a general pervasive mood of unhappiness or depression; or (E) A tendency to develop physical symptoms or fears associated with personal or school problems.

## CAUSES:

Not been adequately determined suggested causes are heredity, brain disorder, diet, stress, and family functioning

## INCIDENCE:

About .7% of school age population

## CHARACTERISTICS:

- hyperactivity
- aggression/self injury
- withdrawal
- immaturity
- learning difficulties

## TEACHING CONSIDERATIONS:

- C encourage developmental skills, social skills, increasing self-awareness, self-esteem, and self-control
- C techniques such as applied behavior analysis, life space interviewing, and conflict resolution

# DEAFNESS AND HEARING LOSS

## DEFINITION:

Hearing impairment - an impairment in hearing, whether permanent or fluctuating, that adversely affects a child's educational performance

Deafness - a hearing impairment that is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification (usually loss is greater than 90 db)

## INCIDENCE:

About .1% of the school-aged population

## CHARACTERISTICS:

- C hearing impairments can be in one or both ears in loudness (dB) or pitch (Hz). hearing loss can be mild, moderate, or profound.
- C conductive - outer or middle ear (person is helped with hearing aid, medically or surgically)
- C sensorineural - damage to sensory hair cells of inner ear or nerves supplying it (with amplification sounds can be distorted)
- C mixed - combination of conductive and sensorineural
- C central - damage or impairment to the nerves or nuclei of the central nervous system (pathway or brain itself)

## TEACHING CONSIDERATIONS:

- C early identification and intervention
- C speech, language, and auditory training
- C interpreting services
- C favorable seating
- C instruction for teacher and peers alternative communication system

# SPINA BIFIDA

## DEFINITION:

- C Spinal Bifida Occulta: opening in one or more vertebrae (bones) of the spine with no apparent damage
- C Meningocele: meninges, or protective covering around the spinal cord, has not pushed out through the opening in the vertebrae in a sac called the meningocele - the spinal cord remains intact - little or no damage to nerve pathways
- C Myelomeningocele: most severe form whereby a portion of the spinal cord protrudes through the back

## INCIDENCE:

40% may have spina bifida occulta, one out of every 1000 have the other two forms with 96% having myelomeningocele

## CHARACTERISTICS:

1. myelomeningocele - loss of sensation, muscle weakness or paralysis below the area of the spine where the incomplete closure occurs, may have loss of bowel and bladder control, large percentage may have hydrocephalus which can be resolved through surgical shunting that relieves fluid build-up in the brain

## TEACHING CONSIDERATIONS:

- C flexibility to accommodate a series of options
- C help managing bowel and bladder
- C learning problems paying attention, expressing or understanding language, grasping reading and math
- C inclusion
- C mobility with crutches, braces, or wheel chairs
- C encourage participation

# VISION IMPAIRMENTS

## DEFINITION:

Vision impairment is the consequence of a functional loss of vision, rather than the eye disorder itself.

- C partially sighted - indicates some type of visual problem
- C low vision - individuals with sight who are not able to read the newspaper at normal viewing distance
- C legally blind - students learn via braille or other media

## INCIDENCE:

For individuals under 18 is 12.2 per 1000. Severe visual impairments occur at a rate of .06 per 1000

## CHARACTERISTICS:

- C depends on the severity, type of loss, age of onset, overall functioning (child may have other disabilities)
- C children may have little reason to explore
- C may not be able to understand social or nonverbal cues

## TEACHING CONSIDERATIONS:

- C early intervention
- C specialized equipment and technology
- C interdisciplinary approaches
- C emphasize listening, communication, orientation and mobility, vocation/career options and daily living skills
- C for low vision - use combination of vision and other senses to learn, may require adaptations in lighting or the size of print and sometimes braille

# TRAUMATIC BRAIN INJURY (TBI)

## DEFINITION:

Acquired injury to the brain caused by an external physical force, resulting disability. Injuries result in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgement; problem solving; sensory; perceptual and motor abilities and/or psychosocial behavior; physical functions; information processing; and speech.

## INCIDENCE:

One million children sustain head injuries annually and 165,000 require hospitalization. Not all children are hospitalized or receive medical attention

## CHARACTERISTICS:

Can vary - may have physical, cognitive or psychosocial

## TEACHING CONSIDERATIONS:

- C follow-up with hospital or rehabilitation
- C may remember their functioning before the head injury
- C may have difficulties orienting
- C provide repetition
- C demonstrate new tasks
- C be concrete
- C reinforce increased attention to tasks
- C repeated practice
- C compensatory Strategies
- C be prepared for fatigue
- C keep environment distraction free

# Generic Instruction Plan - Example

When Jamie's peers are Participating in:	Jamie Can:
Lessons at their desk	<ul style="list-style-type: none"> <li>-be called upon to participate</li> <li>-have an aid volunteer for Jamie to answer</li> </ul>
Classroom jobs	<ul style="list-style-type: none"> <li>-have a buddy to facilitate his participation</li> <li>-address each person as he does the job for them (i.e. take snack plate and say "thank you, John")</li> </ul>
Circle time	<ul style="list-style-type: none"> <li>-hand out objects by going to each person</li> <li>-pick up objects by going to each person</li> </ul>
Group activities	<ul style="list-style-type: none"> <li>-be in a group with a buddy</li> <li>-participate with the help of an aide</li> <li>-be the focus of a group (i.e. the group's purpose is to help Jamie do "x")</li> </ul>
Lunch/Snack	<ul style="list-style-type: none"> <li>-eat with his peers at the snack table</li> <li>-eat with a small group of peers in a quiet place in the classroom</li> </ul>
Outdoor Play	<ul style="list-style-type: none"> <li>-be included in structured games</li> <li>-be included in higher level games with assistance</li> <li>-play board games with a buddy</li> <li>-play go fish with a peer</li> <li>-play balloon volley ball</li> </ul>

Rainforth & York-Barr (1997)  
 adapted from student project:  
 Nancy M. Reed OTR/L

# Generic Instruction Plan

When \_\_\_\_\_'s peers \_\_\_\_\_ can:  
(child's name) (child's name)  
are participating in:


may be photo copied for use

Embed Teaching Strategies

Least Intrusive



- Increased Experiences (Stimulation)
- Opportunities for Practice



- Environmental (Natural) Cues



- Modeling A Child



- Modeling Demonstration from Adult



- Verbal Direction



- Cueing with Contrived Cues



- Prompting

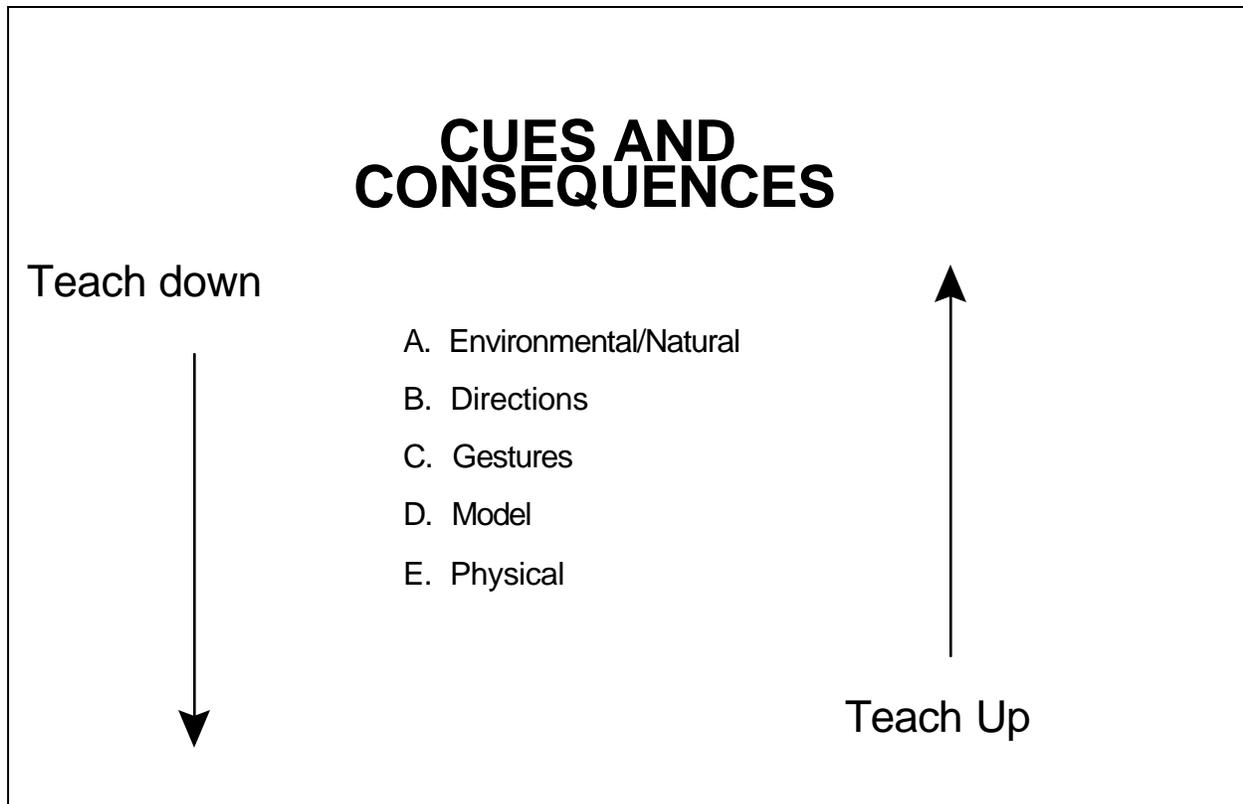


**Adult-Directed Strategies**

(Selected Examples)

Most Intrusive

- Physical Guidance or Assistance
- Therapeutic Facilitation
- Contrived Practice (Discreet Trial Training)



**Teach Down** – gradually add in cues until the child is successful. When the child is successful, gradually eliminate (or fade) cues until the child can perform under natural circumstances.

**Teach Up** – provide physical assistance, demonstration (models), use gestures, give verbal directions, using only the amount of support that the child needs to be successful. When the child is successful, gradually eliminate (or fade) cues until the child performs under natural circumstances.

# REFERENCES & RESOURCES

Batshaw, M., Ed. (1997). Children with disabilities (fourth edition). Baltimore, MD: Paul H. Brookes.

Bricker, D. & Cripe, J. W. (1992). An activity based approach to early intervention. Baltimore, MD: Paul Brookes.

Campbell, P. H. (1992). Physical impairments. Encyclopedia of early childhood education (pp. 326-327). New York: Garland.

Coling, M.C. (1991). Developing integrated programs: A transdisciplinary approach for early intervention. Tucson, AZ: Therapy Skill Builders.

Cook, R. E., Tessler, A., Klein, M. D. (1996). Adapting early childhood curricula for children in inclusive settings (4th Ed.). Englewood Cliffs, NJ: Prentice Hall.

Deiner, P.L. (1983). Resources for teaching young children with special needs. New York, NY: Harcourt, Brace Jovanovich.

Graff, J.C., Mulligan, M., Guess, D., Taylor, M., & Thompson, B. (1990). Health care for students with disabilities: An illustrated medical guide for the classroom. Baltimore, MD: Paul H. Brookes.

Hundert, J., Mahoney, B., Mundy, F., & Vernon, M.L. (1998). A descriptive analysis of developmentally appropriate and social gains of children with severe disabilities in segregated and inclusive preschools in southern Ontario. Early Childhood Research Quarterly. 13(1), 49-66.

Janko, S., & Porter, A. (Eds.). (1997). Portraits of inclusion through the eyes of children, families, and educators. Seattle, WA: Early Childhood Research Institute on Inclusion.

Marguace, M. (1996). Including all children everywhere. Scholastic Early Childhood Today, November/December, 24-25.

Miller, R. (1996). The developmentally appropriate inclusive classroom in early education. Albany, NY: Delmar.

Orelove, F. & Sobsey, D. (1991). Educating children with multiple disabilities: A transdisciplinary approach (2nd edition). Baltimore, MD: Paul Brookes.

Paasche, C.L., Gorrill, L., & Strom, B. (1990). Children with special needs in early childhood settings. Menlo Park, CA: Addison-Wesley.

Safford, P.L. (1989). Integrated teaching in early childhood: Starting in the mainstream. White Plains, NY: Longman, Inc.

Urbano, M.T. (1992). Preschool children with special health care needs. San Diego: Singular.

York, J. & Rainforth, B. (1991). Developing instructional adaptations. In F. Orelove & D. Sobsey, Eds. (1991). Educating children with multiple disabilities: A transdisciplinary approach, 2nd edition (pp. 259-296). Baltimore, MD: Paul Brookes.

## Websites

Websites are a valuable resource for learning more about particular areas and for downloading information that can be used in training. Many websites are linked to other websites, providing easy access to related sites. However, website addresses may change. The most up to date listing of resources may be found at

[http://www.fpg.unc.edu/~scpp/nat\\_allies/na\\_resources.cfm](http://www.fpg.unc.edu/~scpp/nat_allies/na_resources.cfm) or

[www.nectac.org](http://www.nectac.org)

