Reading Guide

CHDV C241 Curriculum and Strategies for Children with Disabilities and Delays

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Introduction

Welcome to CHDV C241 Curriculum and Strategies for Children with Disabilities and Delays. In this course we will be exploring curriculum and intervention strategies for working with children with special needs in partnership with their families. The course focuses on the use of observation and assessment in meeting the individualized needs of children in inclusive and natural environments. This includes the role of the teacher as a professional working with families, collaboration with interdisciplinary teams, and cultural competence.

CHDV C241 is organized into eight modules and is a late-start, short-term course presented in the second half of the semester, the last 8 weeks. The readings presented here are required readings for the course. I do reserve the right to update and change the readings if I find new or interesting articles that pertain to the topics as we work through the course and students express interest in certain topics.

The readings are organized according to the modules and there is a complete References page at the end to assist with in-text citations and References in APA, required for discussions and assignments throughout the course.

Please refer to the syllabus, orientation module, and assignment directions for specific information about each assignment in the course.

Please let me know if you have any suggestions for making this resource useful, it is always in development.

I look forward to seeing you in class.

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CHDV C241 Reading Guide

Module 1: An Inclusive Approach to Early Education

This is an interesting course because it builds on the information learned in CHDV C141 Introduction to Children with Special Needs by focusing on how to support children in the early education classroom. We get to apply developmental knowledge and knowledge about normal and exceptional development to providing developmentally appropriate and supportive curriculum for children with special needs. We will look at how to provide an inclusive classroom environment to support the development and learning of all children.

I'm not sure where the idea is from, but the learning environment is often described as an additional teacher. We often forget how important the learning environment is for all of us. In this module we will explore the concepts of inclusion and universal design for learning (UDL) and how they can be applied to the early childhood learning environment to support the growth, development, and learning of ALL children.

How Does Inclusion Support Progress?

Instructions

Turnball et al. (2016b) define inclusion and identify the main characteristics of this practice. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Ann Turnbull, Rud Turnbull, Michael L. Wehmeyer, and Karrie A. Shogren in *Exceptional Lives: Special Education in Today's Schools (8th).* 2016b

Inclusion is an important way to support students' learning and is one of IDEA's requirements. IDEA has a principle called the *least restrictive environment.* This principle underlies inclusion: Students with disabilities should participate in the school's academic, extracurricular, and other activities with students without disabilities.

What is Inclusion?

Students in particular disability categories may be more likely to be served outside of the general education classroom. It is important, though, that you understand that a disability label is not destiny when it comes to placement. There are examples of successful inclusion across age and disability categories, and it is IDEA's presumption that students with disabilities, independent of category, be educated with their nondisabled peers. So what exactly is meant by

inclusion? Inclusion is based on IDEA's principle of the least restrictive environment. IDEA's presumption in favor of inclusion declares that "each state must establish procedures to assure that, to the maximum extent appropriate, children with disabilities ... are educated with children who are not disabled, and special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability of a child is such that education in regular education with the use of supplementary aids and services cannot be achieved satisfactorily."

Inclusion, then, refers to the participation of students with disabilities alongside their nondisabled peers in academic, extracurricular, and other school activities. The provision of supplementary aids and services is important to IDEA's emphasis. Supplementary aids and services are defined as "aids, services, and other supports that are provided in general education classes, other education-related settings, and in extracurricular and nonacademic settings, to enable children with disabilities to be educated with nondisabled children to the maximum extent appropriate." These aids and services facilitate placement in and compliance with the regulations for the least restrictive environment: "to the maximum extent appropriate, children with disabilities ... are educated with children who are nondisabled." IDEA allows placements other than the general education classroom, but it presumes that the setting of choice for students is the general education classroom and that students will not be removed from that setting unless inclusion in the general education classroom cannot be achieved satisfactorily *with* the use of supplementary aids and services and specially designed instruction.

Characteristics of Inclusion

Inclusion has four key characteristics: home-school placement, the principle of natural proportions, restructuring teaching and learning, and age-and grade-appropriate placements.

Home-School Placement. Within an inclusive model, students attend the same school they would have attended if they did not have a disability. This is the same school other children in the student's neighborhood attend, contributing thereby to the education of other students (Munk & Dempsey, 2010).

Principle of Natural Proportions. The principle of natural proportions holds that students with exceptionalities should be placed in schools and classrooms in natural proportion to the occurrence of exceptionality within the general population (Brown et al., 1991). If, for example, 10 percent of students in a school district receive special education services, the principle of natural proportions holds that, if a classroom has thirty students, not more than three should have a disability.

Restructuring Teaching and Learning. Inclusion through restructuring requires general and special educators to work in partnership with related service providers, families, and students to provide supplementary aids and services and special education and related services. Tremendous variability exists in how teachers provide special education services within general education classrooms. In schools that implement inclusion through restructuring, pooling the

strengths and talents of educators who have different types of training and capacities allows all students to be successful in the general education classroom.

Age- and Grade-Appropriate Placements. Finally, inclusion favors educating all students in age- and grade-appropriate placements. Two major issues are at the heart of the inclusion debate: (1) eliminating the continuum of placements and (2) increasing the amount of time students spend in the general education classroom.

Eliminating the Continuum of Placements. The concept of a continuum of services has been part of special education ever since Congress enacted IDEA in 1975. The continuum refers to services that range from the most typical and most inclusive settings to the most atypical and most segregated settings.

There was a time when accommodating students with disabilities in general education classrooms through supplementary aids and services was not considered an option. That limited perspective caused Taylor (1988) to observe that students with disabilities were caught in the continuum of services. Unfortunately, once students were placed in more restrictive settings, few ever left them for general education classrooms.

The inclusion movement has tried to limit the need for more restrictive settings by creating a new partnership between special and general educators. This partnership seeks to provide individualized instruction to students in general education classrooms through a universally designed general education curriculum (Jackson, Ryndak, & Wehmeyer, 2010). The priority for inclusion in the general education classroom is now predicated on the premise that it is not often appropriate or even necessary to remove some students from the general education classroom and place them in a more specialized and restrictive setting to provide individualized and appropriate education; that in order to gain access to the general education curriculum, students must be in the general education classroom (Wehmeyer, 2011); and that there is now sufficient evidence to support inclusion as a research-based practice (Jackson et al., 2010).

Increasing the Amount of Time in General Education Classrooms. Research confirms that students with disabilities can be successfully educated in the general education classroom, given adequate support and instruction (Jackson et al., 2010), and IDEA expresses a preference for inclusion.

Barriers to Including Young Children with Disabilities

Instructions

Brillante (2017b) identifies challenges to offering inclusive programs for young children. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Pamela Brillante in *The Essentials: Supporting Young Children with Disabilities in the Classroom.* 2017b

There are legitimate challenges and barriers that states, programs, and families face when promoting and providing inclusive opportunities for children with disabilities. The joint policy statement on inclusion from the US Departments of Health and Human Services and Education identifies several challenges to inclusive programming for young children:

- **Attitudes and beliefs of parents and educators.** Many programs report significant misinformation among families and educators about the benefits and practicality of inclusive programs in schools and communities. Many people worry that including children strains the classroom teacher's resources, resulting in the needs of both the children with disabilities and the children without disabilities going unmet. While this challenge can be overcome in programs with strong collaboration among teachers and specialists and support form administrators, when these are lacking it is a very real concern.
- **Lack of expertise of the early childhood workforce.** Many early childhood educators believe they lack knowledge about individualized instruction, child development, and early childhood pedagogy that is needed to effectively educate children with disabilities alongside their peers.
- **Lack of comprehensive services.** Children with disabilities frequently receive related, specially designed instruction from professionals in speech-language therapy, physical therapy, and occupational therapy. However, expertise in these areas may not be available in private childcare programs in the community, and bringing in outside resources can be costly. When such resources *are* available, too often teachers are not shown how to implement therapy practices in their daily routines with children.
- **Limited time and commitment to build partnerships.** Therapists and special education teachers or early intervention providers often lack the time to collaborate with each other, or with classroom teachers and families, on the goals they are working on with the child and to share the progress or challenges they are seeing. This lack of time and commitment to coordinate services inhibits the development of the strong relationships among the professionals who help make inclusive programs more successful.

Identifying the Supports Children Need

Instructions

Brillante (2017c) provides modifications that can assist teachers in inclusive classrooms. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Pamela Brillante in *The Essentials: Supporting Young Children with Disabilities in the Classroom.* 2017c

To help children be successful in the general education classroom, first identify your expectations for all children within the typical routines, activities, and lessons of the day. Doing so lets you see the barriers a child with a disability may have with access or participation, and then you can start problem-solving to remove those barriers and meet children's specific needs. Begin by considering simple curricular modifications you can make.

Curricular Modifications

Researchers Sandall and Schwartz (2008) identified several simple curricular modifications as part of what they call the "building blocks" needed to promote high-quality inclusive practices and improve educational outcomes for children with disabilities. With the foundation of high-quality early childhood classrooms as the first building block, you can add one or more of these curricular modifications to change a routine, activity, or material and provide children with greater access and participation. Sandall and Schwartz (2008) identify eight curricular modifications:

1. **Environmental supports: A**lter the physical or social environment to encourage children's participation, engagement, and learning. For example, label baskets, folders, or shelves so students know where materials go when they are done with them. To help a child transition to a new activity, give him a picture or symbol of the area showing where he should go next.
2. **Materials adaptations:** Make changes to the way a child holds or uses a material so she can be more independent. Add grips to make pencils, crayons, or markers easier to handle.
3. **Simplify the activity:** Break a task into smaller steps, or change or reduce the number of steps the child does on her own. For example, help a child put on her coat and engage the zipper, then have the child pull the zipper up so she finishes the activity with success.
4. **Child preferences:** Add something a child enjoys to interest him in participating in an activity. If he loves music, find ways to incorporate songs and rhythms into daily routines and activities.
5. **Special Equipment:** Provide equipment and devices that make it easier for a child to participate. This might be loop scissors or specialized technology like touchscreens or large keyboards.
6. **Adult support:** Have an adult take part in an activity to support the child as necessary. For example, follow alongside the child in an outdoor obstacle course, prompting him to do the next step only when he needs prompting.
7. **Peer support:** Use a child's peers as models or to support the child during activities only when he needs it. For example, assign everyone a buddy, partnering children who have

a delay or disability with their same-age peers. Buddies can model what to do during a game or activity for the children with disabilities and provide minimal support as needed.

8. **Invisible support:** Intentionally plan or arrange the order of when children participate. For example, arrange for a child who has difficulty waiting to take her turn early during a group activity. When you ask a question that has multiple answers, choose the child with a disability first if you think it will be difficult for him to think of other answers.

Does Your Child Need Early Intervention?

Instructions

Smith (2014) provides an overview of the types of interventions young children can receive if they are experiencing developmental delays. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Barbara Smith. 2014

If your child is experiencing developmental delays, don't worry. Here's what to know and what you can do to help.

Soon after birth, your child will show off her personality and develop skills such as briefly gazing at objects, communicating that she wants to be held, and fussing to be fed. Although children develop at their own pace, most achieve certain milestones – crawling, walking, saying first words – at around the same age. When children are not reaching expected milestones and are showing significantly delayed development, parents may worry. Suspecting a "delay" is scary, but there may not always be a problem.

If there is a problem, early intervention (EI) services are available to help a child who may have trouble reaching certain milestones. Early intervention means using "therapy services to enhance a child's ability to interact with others and the environment; these everyday experiences and interactions are essential for optimal child development," says Anne Zachry, Ph.D., assistant professor of occupational therapy at The University of Tennessee Health Science Center and author of *Retro Baby*. In 1986 the U.S. Congress mandated an Early Intervention Program (EIP) under the Individuals with Disabilities Education Act (IDEA) to support children's development with funding for all 50 states. EIP services are usually free and available for children under 3 years old who are suspected of having developmental (physical, cognitive, language) delays, disabilities, or special needs. A pediatrician will usually recommend an evaluation.

Does My Child Need Early Intervention?

Many families receive EI services after birth when a genetic or chromosomal disability (for example, Down syndrome) is identified, but other early red flags include sensory sensitivities, refusing to be held, fearing movement, or have feeding difficulties. "Milestones for biting, chewing and swallowing a variety of foods are typically accomplished by age three," says Melanie Potock, a speech and language pathologist in Longmont, Colorado, and author of *Happy Mealtimes with Happy Kids*.

Types of Early Interventions

Early intervention begins with a team evaluation to identify a child's needs. "Research reveals that early intervention services can considerably mitigate the effects of developmental delays. Physical, occupational, and speech therapy services may be necessary in order to promote motor skills, speech, and language development," Dr. Zachry says. Early intervention services may include counseling, social work, therapies (occupational, physical, and speech), psychological services, audiology, and vision services. These services can be as simple as recommending hearing aids for a baby who has a diagnosed hearing loss or eyeglasses for a toddler who does not look at pictures, or they can be as complicated as involving a team of professionals who help a child with cerebral palsy sit in a chair to feed herself.

"Professionals will team together to boost coordination, strength, and stability while supporting a child's sensory needs and address goals to help a child thrive at preschool, on the playground, and at mealtimes," Potok says. EI services are provided at an EI center or at home during in-person visits, and the earlier these services are utilized, the better.

Occupational Therapy

Occupational therapy helps promote the cognitive, visual, sensory, and motor skills to grasp and manipulate objects. Occupational therapy can help develop concepts such as size and shape discrimination (so that kids can fit smaller objects inside larger ones), hand-eye coordination to use a spoon, and sensory skills to scribble on a tray covered with shaving cream.

Speech and Language Therapy

Speech and language therapy is also referred to as speech language pathology (SLP), which helps promote receptive and expressive communication and the oral motor skills to speak and swallow. Speech therapy may include using speech, pictures, gestures, and electronic devices.

Physical Therapy

Physical therapy helps promote stability during sitting or standing and mobility to crawl and walk. Physical therapy also helps address kids' needs for any adaptive devices such as walkers and wheelchairs.

Early Childhood Special Education

Early childhood educators help provide developmentally appropriate learning environments and activities to promote cognitive and social skills, such as singing finger-play songs and asking for more bubbles to pop.

Social Work Services

Social work services assess the social and emotional needs of a child and his family and provide help with counseling or parent training.

How Do I Get Early Intervention?

All kids with developmental delays who live in the U.S. are entitled to free early intervention services through age 3 and free special education from age 3 through 21, thanks to the Individuals with Disabilities Education Act (IDEA). The first step is to get an evaluation through your state’s education department. To schedule an appointment, ask your child’s doctor for a referral or Google “early intervention” and your state for contact info.

Eligible families will then get a personalized plan—called an Individualized Family Service Plan for infants and toddlers and an Individualized Education Program for preschoolers. These explain which services would be helpful for the child and how to sign up for them. EI therapists can come to your home or even to your child’s daycare or preschool, where they’ll work with the teachers to find an appropriate place and time for the sessions.

Every state has its own guidelines, but children with issues such as cognitive disabilities, vision or hearing problems, gross motor delays, feeding problems, speech delays, and more may all be eligible for services.

Universal Design

Instructions

Brillante (2017e) identifies 7 key elements of Universal Design through the lens of developmentally appropriate practices. Be sure to take notes since you are expected to

incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Pamela Brillante in *The Essentials: Supporting Young Children with Disabilities in the Classroom.* 2017e

To effectively support the needs of all children in your classroom or program, think about ways to design the classroom space, routines, and activities so they are adaptable and can be used with and by many children in a variety of ways. With flexibility built into the design from the start, all children can access the curriculum, process information in a way that works for them, and demonstrate what they know (Conn-Powers et al., 2006). With a continued focus on developmentally appropriate practices and your school's or program's learning standards, this proactive approach supports children's strengths and balances the needs of all children. It is the most efficient and effective way to develop inclusive classrooms and programs.

This concept of proactive design and flexibility, known as **universal design** (UD), was first applied to architecture. For example, when new buildings are designed, ramps are built in place of, or in addition to, stairs, allowing anyone to enter and travel throughout the buildings. Some people are able to use stairs, but a ramp is flexible enough for anyone to use. Similarly, automatic doors that open by themselves when a person approaches a store or other building make entry and exit more flexible, which in turn enables more people to use it - and not just those with disabilities. A person pushing a child in a stroller or pulling luggage may find it easier to use ramps and automatic doors, too. Applying this process of UD proactively results in environments that can be used by everyone in a similar manner.

The concept of UD is also applied in the context of teaching and learning. In the early 1990s the Center for Applied Special Technology (CAST) began promoting the concept of **universal design for learning** (UDL) as a way to design curriculum to include many options for accessing clear goals, flexible materials and methods, and embedded assessment to support the needs of many different learners (Rose & Meyer, 2006).

While the principles of UDL have piqued the interest of many early childhood teachers and school leaders, current evidence-based classroom practices using the principles of UDL frequently focus on the needs of children in upper elementary, high school, and college classes to access materials such as textbooks and online learning opportunities (Meyer, Rose, & Gordon, 2014). While some UDL practices may not be as applicable to classrooms and programs that serve young children, the bigger concept of universal design can be used to increase access and success for children of all ages.

Using the principles of universal design in early childhood classrooms and programs as a framework to design learning environments, routines, and activities to make them as flexible and responsive as possible provides supports for all children and reduces the barriers for children with disabilities. Just as ramps and automatic doors help people without disabilities, UD

practices can help children who do not have disabilities, including those who speak a home language other than English or who have developmental delays but not disabilities. UD practices are also useful to consider in your collaboration with families. Provide multiple means for sharing program and child information with families, different opportunities for them to support their child at home and in the program, and many ways for them to be involved.

When designing or redesigning your classroom or program spaces and activities, consider the seven principles of universal design through the lens of developmentally appropriate practices (The Center for Universal Design, 1997).

1. **Equitable use:** All children use the same materials and spaces, which avoids segregating or calling undue attention to a child with a disability. Instead of an easel for a child who uses a wheelchair and an art table for everyone else, easels are set up for everyone to use. The entire curriculum engages children with diverse abilities.
2. **Flexible use:** Children use the same materials and curriculum as everyone else but in varied ways or with adaptations to accommodate a disability or personal preference. Switches added to cause-and-effect toys make them more manageable to activate. Books with paper clips attached to the pages enable a child to turn the pages more easily. Children learn concepts and practice skills at their own pace.
3. **Simple and intuitive:** The design of the spaces and materials is easy for everyone to understand. Every material has a specific place and is labeled in different ways, making finding and cleaning up materials easy to understand and accomplish.
4. **Perceptible information:** The spaces and materials provide information to children in a number of ways. Pictures, word (in English and children's home languages), and braille are used together to bring meaning to children with language delays or vision impairments and to dual language learners (children learning English while continuing to develop their home language). Beginning braille signage is posted around the classroom for children who have vision impairments and will be braille readers. Lights flicker when the fire alarm goes off so children with hearing impairments understand the same information as everyone else in the classroom.
5. **Tolerance for error:** Teachers design learning environments and materials that provide ongoing assistance and accommodate children when they don't get things correct the first time. The design eliminates or minimizes hazards and limits the frustration some children feel when they make mistakes. Some wooden blocks can have felt attached to one side, making them less likely to fall over if a child inadvertently knocks into them while building. The settings on classroom touchscreen computers or communication boards can be adjusted so they do not react to an unintended touch. Software or apps have an undo button so children can go back. Older children can work with easy-to-write-with markers and erasable whiteboards for some tasks typically done with paper and pencil.
6. **Low physical effort:** Spaces and materials are set up, so they are easier to use by all children. Automatic soap and paper towel dispensers in the bathroom, along with a sink that turns on and off when children place their hands under the faucet, reduce the physical effort needed by children with low strength or who use a wheelchair. Instructional materials are accessible, and the schedule allows for varying energy levels.

7. **Size and space for approach and use:** Spaces in the classroom allow everyone physical access and encourage learning. There are chairs for children who use wheelchairs to sit at the table, so they are at the same eye level as their classmates. Outdoor areas have ramps and are accessible in other ways to children with physical needs. There are spaces for small and large group activities and lessons, places for one or two children to work together, and quiet retreat areas.

Universal Design in the Classroom Checklist offers helpful questions to consider about UD and ways to incorporate its practices in your own setting.

How Traditional Classrooms Differ from UDL

Instructions

The CDE (2019) has been focusing on Universal Design for Learning (UDL) these last few years. Here they provide information on how traditional and UDL classrooms differ. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By California Department of Education (CDE) in *California Practitioner's Guide for Educating English Learners with Disabilities.* 2019

Traditional and one-size-fits-all classroom approaches differ from universal design for learning (UDL) classrooms in significant ways.

Traditional Classrooms	UDL Classrooms
Teaching is a one-size-fits all approach	Teaching focuses on both the content and in what ways using many approaches to reach a diverse range of learners.
Differentiation is for specific students only (e.g., accommodations for a student with an IEP or Section 504 plan)	Differentiation is for all students with the goal of providing access to rich learning.
The teacher decides how the material is taught	The teacher confers with students, providing student choice when possible, and facilitates how students will learn.

The classroom has a "fixed" physical setup	The classroom has a flexible setup, and both teacher and students have multiple options (e.g., small group, whole group, standing, sitting)
There is only one way to complete an assignment or assess student progress and learning	There are multiple options for students to demonstrate their learning; ways that are not limited by narrow understanding of standards.
Grades are the only way to measure performance	Students are given continuous and meaningful feedback on their learning and progress through formative assessment processes and other assessment methods. Students set learning goals with the teacher and reflect on their learning periodically.

6 Myths about Universal Design for Learning

Instructions

Novak (2020) outlines 6 myths about universal design for learning (UDL) and provides explanations of various components and how UDL supports children's learning. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Katie Novak, 2020

You may know of UDL as a framework to improve and optimize teaching and learning for all people based on scientific insights into how humans learn. But one thing I have experienced time and time again from my experience presenting on the topic is that there are several myths and misconceptions about UDL that are common among educators. Addressing these myths may be helpful in implementing the framework in your school or district.

Myth #1: UDL is for Special Education Students

Every student regardless of variability deserves the best opportunity to develop their skills and knowledge, especially those students who have been historically marginalized. It is true that UDL grew out of efforts to help students with disabilities. The innovation came in realizing that lowering barriers for students with disabilities also lowered previously unseen barriers for other learners. This, in turn, led to a recognition that universally designed education would

encompass all learners because human variability is not this/that, either/or but rather a continuum of differences that change according to context and opportunity.

All students, in a classroom that includes students with disabilities, are given options and choices so they can be equally challenged and supported. Even students who are identified as gifted and talented benefit from inclusion when three key components are met: flexibility, acceleration, and variety (Delisle, 1999). Essentially, the flexibility provides all students with options and choices for the methods they use to learn, the materials, and the assessments. Acceleration allows students to move at a quicker pace if they show competency of the material, and lastly, variety allows students to personalize their learning and create meaning for themselves as they work toward standards. All three of these conditions are required in the UDL framework.

Myth #2: UDL is Differentiated Instruction (DI)

UDL and DI are built on fundamentally different values of who is in charge of a student's learning. The primary goal of UDL is to create expert learners. UDL honors student variability and removes barriers to student learning by embracing differences.

When teachers differentiate instruction, they cater to individual student needs (Tomlinson, 2000). For example, you may take one group of students aside and ask them to read an extra piece of literature because you have evidence that they are more advanced than their peers. You ask another student to draw pictures instead of writing an essay since you know writing is challenging for him.

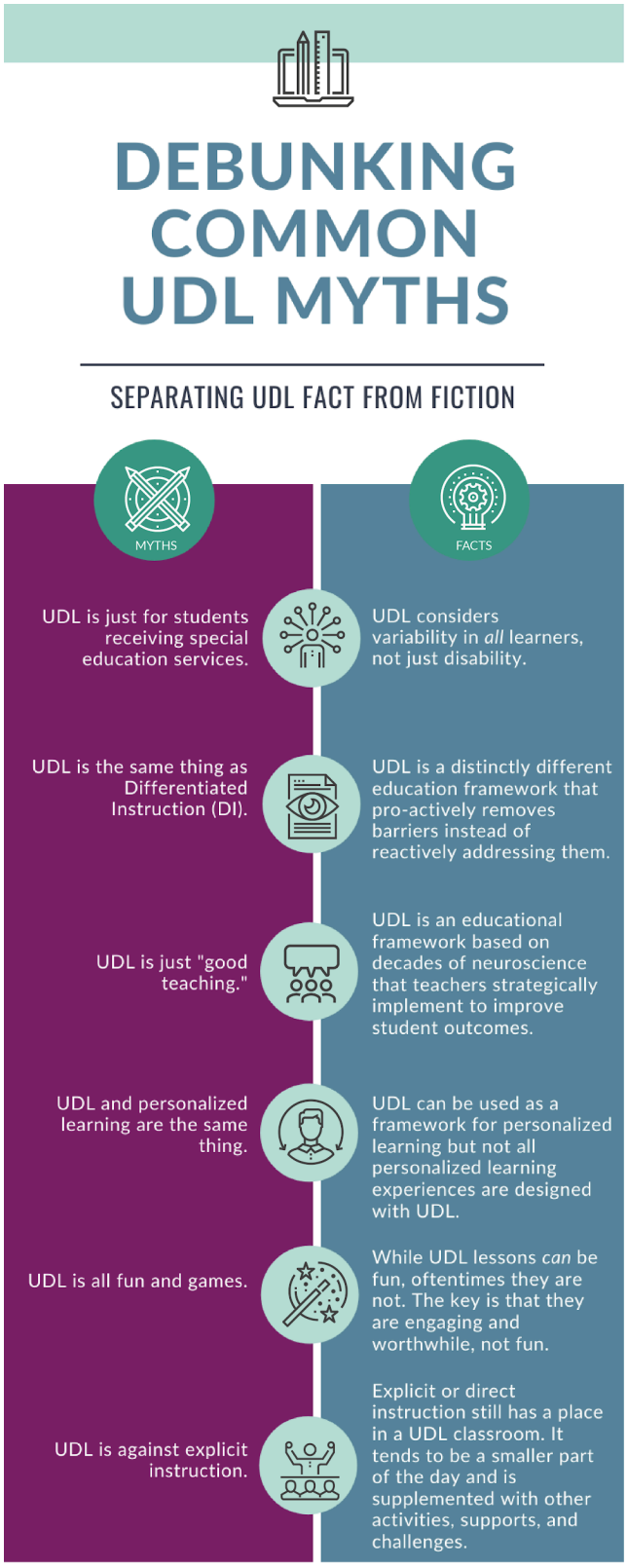
On the contrary, UDL proactively designs flexibility in goals, methods, materials and assessments by embracing variability and predicting barriers, and then eliminating those barriers through design. These frameworks complement each other in a multi-tiered system. When predicting variability, educators can design robust opportunities for all learners to access grade-level rigor in Tier 1 with UDL. When evidence suggests that students need additional support, intervention, or enrichment, teachers can differentiate instruction to supplement, not supplant, universally designed learning experiences.

Myth #3: UDL is just "Good Teaching"

There is no variable more critical for student success than the quality of teachers (Hall & Simeral, 2017). Without a doubt, the best investment a school can make is in its human resources. Teaching is the foundation of learning, and so when we have so many students who are not successful in school, and who haven't learned standards, we have to re-evaluate what good teaching is.

UDL is an educational framework based on decades of research in learning and the brain. It takes years to master and teachers use it to strategically remove barriers in lesson design by focusing on providing multiple means of engagement, representation, and action & expression. Teachers aim to create instructional experiences that allow students to become purposeful and motivated, resourceful and knowledgeable, and strategic and goal directed, also known as

“expert learners.” In a nutshell, while following UDL best practices is good teaching, good teaching isn’t always universally designed instruction.



When UDL is successful, learners truly have ownership in their learning, as opposed to permission to make choices. One great resource to exemplify this is the UDL Progression Rubric (Novak & Rodriguez, 2018). What you will notice is that some “good teaching” strategies, where teachers offer options and choices to students, are only identified in the “emerging” UDL category. That is because UDL is all about learning, and UDL implementation is only approaching an expert level when all students, regardless of variability, are learners who understand the importance of setting goals, and creating pathways to meet those goals.

Myth #4: UDL is the Same as Personalized Learning

Many people will also say that UDL simply allows each student to go their own way and demonstrate what they know and that it results in personalized learning. Although there are some similarities, the two terms are not synonymous.

Personalized learning (PL) is when educators cater to the strengths, interests, and needs of students through instructional strategies, personalized goals, and mastery-based assessments in flexible learning environments (Bingham & Dimandja, 2017). As outlined in a research paper that reported on the results of a multiyear, multimethod study of nearly forty (40) schools implementing PL, “Personalized learning is not a codified program or set of practices that schools can readily adopt.” Elizabeth Steiner of the RAND Corporation explained that her recent studies of personalized learning suggest that “what’s happening in the field right now is a lot of innovation and a lot of schools building their [personalized learning] models, building their curriculum, and inventing new systems” (Herald, 2017).

Using that definition, Universal Design for Learning (UDL) is a framework that could be used to implement and optimize personalized learning, but it isn’t explicitly required as a component of the initiative. As the field of personalized learning continues to scale, we are hopeful that UDL will emerge as the primary framework for allowing all students to thrive.

Myth #5: UDL is all about Fun!

Learning doesn’t have to be fun to be effective. It does, however, need to be engaging, challenging, and worthwhile. Take a favorite hobby, for example, and consider if it’s “fun” all the time. It’s not. Sometimes it sucks. The Spartan Beast is a half-marathon up a mountain with 30 obstacles including delights such as getting scratched by barbed wire and lugging 40 pounds logs up a steep incline. It’s incredibly rewarding and requires expert learning, but at the time – not fun.

UDL is sometimes mischaracterized as a way of teaching and learning that is fun because when teachers proactively design flexible learning experiences with multiple options, learners have choices which makes them more likely to choose tasks that they find engaging.

But thinking that the intent of UDL is fun allows a scientific framework to be brushed off as a fad or lacking in rigor. I have designed very fun UDL lessons, and I have also designed lessons where learners were working extremely hard, pushing their intellectual abilities to the limit, stressed, and engaged, but not having fun.

Myth #6: UDL is Anti Explicit Instruction

All too often educators think that there is no place for direct or explicit instruction in a UDL classroom. This couldn't be further from the truth. Direct instruction will always have a place in education, but the way direct instruction is delivered through UDL is quite different. To support the direct instruction, teachers provide students with options and choices to help support their learning and offer multiple ways to students to dive more deeply into the information covered through direct instruction, for example by choosing to read a chapter in a book, watching a video, discussing the concepts learned with a peer, or diving into an experiment. Whichever option the student chooses, there will be resources available to help them through struggles, such as scaffolds and exemplars. There will be frequent reminders about the goals of the lesson, and classroom norms to support students with finding resources when they are challenged. So, while a lesson may incorporate mini-lessons and direct instruction, UDL encourages teachers to go beyond the "sage on the stage" of the olden days and help students take charge of their own learning.

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Universal Design in the Classroom Checklist

Instructions

Brillante (2017f) developed a checklist for identifying the various components of UDL are present in classroom practices. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your

original response to the discussion prompt as well as the assignments you complete throughout this course. This checklist will be used for PA: Observing for Universal Design Components.

Learning Resource

By Pamela Brillante in *The Essentials: Supporting Young Children with Disabilities in the Classroom.* 2017f

Classroom Practices	Does/is my classroom…	What can I do to incorporate this practice?
Physical Environment	Accessible for all children?	Make sure children can use each part of the classroom in a similar way. If everyone sits on the carpet for group time or a class meeting, provide a way for a child with a disability to do so without needing an adult to hold or support her. Work with a physical therapist to design accessible spaces for children with physical disabilities. Work with other professionals to design spaces if the child has other sensory needs. Find ways to absorb background noise that can distract children as they are learning.

	Include equipment and materials that are easy to use by everyone?	Provide ways for children to access all of the materials in the room as independently as possible. Identify containers of materials to help a child with a visual impairment recognize what is inside. Color-code materials so they are easy for children with learning disabilities to match up. For example, cover math workbooks in the same color as children's math homework folders. Provide dress-up items with multiple ways to fasten them. Have a child keep books and other materials on a shelf next to her desk instead of inside a dark desk so the materials are easier to find.
	Designed with safety in mind?	Develop plans and procedures with families and other members of the interdisciplinary team for fires or other classroom emergencies. Develop materials, like class-made books, that help children learn what to expect during a safety drill. Keep pathways clear and free of tripping hazards for a child who uses a mobility device or has a visual impairment.

Class Climate	Welcome everyone, including children who spend part of the day or week in the classroom?	Treat every child as a member of the class, even if he is not in the room full time. Work with the child's other teachers and team members to make educational decisions together. Display every child's work and creations in the classroom. Include everyone in group photos of the class and put each child's name on every class list (especially the ones that go home) so children and families know that the child is a member of your classroom, even if it is only occasionally. Provide elementary-age children with their own space in the classroom (a desk and chair, if that is what the other children use) so they feel included during whole group and small group instruction.
	Avoid stereotyping?	Do not assume that a child with a disability needs assistance with a particular activity or routine. Always give the child time to try to accomplish the task as independently as possible.
	Avoid segregating or stigmatizing any student?	Encourage other adults in the classroom to not draw unnecessary or unwarranted attention to a child with a disability. Avoid having an adult always by the child's side. Support a peer buddy program so children have same-age peers to play with during less-structured time, like in the cafeteria and one the playground.

Interactions	Enable effective teacher-child communication?	Speak directly to the child with a disability the same way you speak to other children. Give him enough wait time to process what you are saying. Model what you *intend* to model for the child's peers who do not have disabilities. Actions speak louder than words, so make sure you are communicating the messages you want them to receive about how to interact with the child with a disability.
	Have multiple ways for children to communicate with each other?	Provide ways for a child who uses little or no speech to communicate with other children without adult assistance. Teach all of the children in the classroom to use the child's preferred method of communication – picture symbols, sign language, and so on – and model it with everyone.
	Encourage cooperative work?	Design activities that require more than one child's participation to accomplish the task. Assign peer buddies, instead of an adult, to assist children with disabilities. Scaffold group work for older students so everyone knows what they are expected to contribute. Remind all children that everyone can contribute something to every activity,

Module 2: Developing Relationships

As early educators there is already so much that we need to be aware of that it can be difficult to find the time and energy to include special education. It is important for every teacher to be aware of the federal legislation that supports the education of children with special needs, whether they work with children with special needs or not. While we reviewed federal and state legislation in CHDV C141, in this module we will look at the implications of those laws in the classroom and how they affect our relationships with the families.

In just about every child development course you take there will be at least some discussion on collaborating and involving families in the early childhood program. We all know the family is where children learn their foundational knowledge about the world in general. However, when working with children with special needs, collaborating with families can take on different meanings and roles and you may be faced with challenging situations. Not only is it important to understand where the child is coming from, it is important to understand the family experience in order to build a working relationship with families to make sure there is an extra layer of consistency, support, and collaboration when trying new techniques, adjusting schedules for developmental support, providing the resources and services varying disabilities need, and advocating for a child's unique skills and needs.

While teaching in and of itself requires a certain set of characteristics to be effective, special education professionals have more requirements and need to have certain dispositions that allow them to support and communicate with the children with special needs and their families. In this module, we will be looking at the different perspectives of developing a family-school relationship to support children with special needs.

Laws Governing Early Intervention and Special Education of Young Children with Disabilities (0-5) with an Emphasis on Assistive Technology

Instructions

Let's Participate Project (2015) provides a brief overview of some of the main laws, legal rights, and protections for children and their families. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Let’s Participate Project. 2015

Laws Concerning Individuals with Disabilities

Rehabilitation Act (P.L. 93-112), 1973

This legislation was the first federal civil rights law to protect the rights of individuals with disabilities. Section 504 protects qualified individuals from discrimination based on their disability: No otherwise qualified handicapped individual in the United States, as defined in section 7(6), shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

For the first time, publicly funded programs had to ensure that people with disabilities could access the programs with "reasonable accommodations." This may include access to the early childcare program in the building, curriculum modifications such as adapted play materials and simple AT supports, providing auditory and visual instruction, and behavioral supports. Section 504 does not require the program/school to provide an Individual Family Service Plan/Individualized Education Program (IFSP/IEP).

Americans with Disabilities Act (ADA) (P.L. 101-336), 1990

This law extends full civil rights to all people with disabilities and affords them the right to fully access public and particular private sector facilities and services. It extends Section 504 by prohibiting discrimination in employment, public accommodation, transportation, state and local government services, and telecommunications. For children with disabilities, the ADA prohibits discrimination and extends the right of access to all educational programs and services, whether or not the school/program receives federal funding. All public and private early childhood programs must provide reasonable access for young children with disabilities. Program accommodations can include such strategies as setting up a quiet area, implementing a behavior management plan, providing a variety of drawing tools, or using a signal to cue a child's behavior. Children with disabilities, even those who are not eligible for special education under IDEA, may also be entitled to the provision of assistive technology under Section 504 of the Rehabilitation Act or under the Americans with Disabilities Act (ADA).

Laws Concerning the Education of Children with Disabilities

The Education for the Handicapped Act (EHA) (P.L. 94-142), 1975

Before 1975, children with disabilities were mostly denied an education solely on the basis of their disabilities. The EHA requires all school districts to educate students with disabilities. This was the first law to guarantee a free and appropriate public education (FAPE) to children with disabilities (then referred to as "handicapped") in grades K–12. Funding to states and school districts is authorized to assist them in providing special education and related services. Federal regulations provide rules to which school districts must adhere when providing an education to students with disabilities. The educational setting for children with disabilities is the "least restrictive environment" (LRE). This means that school districts are required to educate students with disabilities in the schools they would attend if they were not disabled. To identify children with disabilities and support their education, school districts must, in partnership with families, develop a written Individualized Education Program (IEP). The IEP identifies educational goals,

objectives, and intervention plans for each child with a disability. The goals are identified and agreed to by a team of individuals and include the child's parents as well as public school administrators, evaluators, teachers, and therapists. The special services and learning supports the child needs to achieve the goals and objectives are also specified in his or her IEP. They must be free, provided by the public school at no cost to the child's family.

Education of the Handicapped Act Amendments (P.L. 99-457), 1986

These amendments, which are also known as the Early Intervention Amendments to the Education of the Handicapped Act, are the first to extend the right to a free and appropriate public education (FAPE) to all children ages 3–5 (Part B, Section 619). Part B regulates the education of children 3–21. Part C of the amended law creates the Early Intervention Program for infants and toddlers with disabilities (birth to age 3) and their families. The law requires the development of an Individual Family Service Plan (IFSP) for each child and family served. The law creates a system that is family centered, where supports and services are provided in the family's natural environments.

Education of the Handicapped Act Amendments (P.L. 101-476), 1990

These amendments rename the special education law as the Individuals with Disabilities Education Act (IDEA). They replace the phrase handicapped child with child with a disability. Evidence exists that individualized education programs may have been overemphasized and may have limited the benefits that children with disabilities gain within an inclusive curriculum. The amendments strengthen the law's commitment to greater inclusion in community schools by defining least restrictive environment as the same setting in which children without disabilities participate. They also expand the services for children with disabilities, ages 3–21, extend eligibility to children with autism and traumatic brain injury, and designate assistive technology as a related service in a child's Individualized Education Program (IEP). It also requires that, by age 16, each student have a plan for transition to employment or postsecondary education explicitly written in his or her IEP.

The law defined assistive technology device as:

Assistive technology device means "any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability."

An assistive technology service is defined by IDEA 1997 as: "any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device." The term includes:

1. the evaluation of the needs of such child, including a functional evaluation of the child in the child's customary environment;
2. purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by such child;
3. selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

4. coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
5. training or technical assistance for such child, or, where appropriate, the family of such child; and
6. training or technical assistance for professionals (including individuals providing education and rehabilitation services), employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of such child.

Amendments to Individuals with Disabilities Education Act (P.L. 105-17), 1997

These IDEA amendments state that the education of students with disabilities can be made more effective by having high expectations for such children and ensuring their access, participation, and progress in the general curriculum to the maximum extent possible. This includes the general education curriculum, extracurricular activities, or any other program that nondisabled peers would be able to access. Schools must educate students with disabilities to meet the same state standards and pass the same state mandated assessments designed for students without disabilities. Specifically, students with disabilities are to be included in general state and district-wide assessments, with appropriate accommodations including Assisitve Technology devices and services. The law now supports the idea of appropriate instruction for diverse learners in mainstream settings. IDEA includes principles for parent– professional collaboration, thereby strengthening family involvement and participation.

This law strengthened the use of assistive technology devices and services by stating that the IEP team must consider whether the child requires AT to meet IEP goals.

Individuals with Disabilities Education Improvement Act (IDEA) (P.L. 108-446), 2004

This law amends the special education law and builds on each child's right to access, participate, and progress in the general curriculum. It emphasizes the supports and services children need to participate in the general curriculum. Children with disabilities are provided with the supplementary aids and services necessary for them to achieve educational goals in a setting with nondisabled peers. The general curriculum for young children includes the activities, interactions, and learning opportunities provided during daily activities and routines. The same curriculum developed for children without disabilities must be provided to children with disabilities. It also allows schools to support students who have academic and behavioral problems in regular education programs but who are not disabled. These intervention services will be delivered to children earlier and prevent future problems. The law makes some changes to the Individualized Education Program (IEP) that identifies the supports and services needed to enable the child to be successful and to benefit from the general curriculum. It requires the regular education teacher to be on the IEP team and given access to the IEP. To meet the standard of "highly qualified teacher," all special education teachers must be fully certified. Because No Child Left Behind mandates that all children are expected to take part in all state assessments, the IEP must include necessary modifications for state assessments (or a state

may develop an alternate assessment.). These modifications vary from state to state but may include extended test time, a separate testing area, a reader, typing the answers, etc.

In 2004, the Assistive Technology definition was changed to:

Assistive technology device means “any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability. The term does not include a medical device that is surgically implanted, or the replacement of such device”.

The law also regulates:

- where and how AT should be included on the child’s IFSP/IEP: special education, related services or supplementary aids and services
- the use of AT in the home: On a case-by-case basis, the use of school-purchased assistive technology devices in a child’s home or in other settings is required if the child’s IEP Team determines that the child needs access to those devices in order to receive FAPE
- the IEP team considers whether the child needs assistive technology devices and services.

Assistive technology, which includes devices and services, is one of the services required under Part C of the Individuals with Disabilities Education Act (IDEA) of 2004.

- all children who are eligible to receive special education or early intervention services are also eligible to receive assistive technology, if it is included as part of their IEP/IFSP

Laws Concerning the Education of All Children

No Child Left Behind (P.L. 107-110), 2001

This law is the current version of the Elementary and Secondary Education Act (ESEA). It is the federal law that funds basic public-school programs. Its purpose is to promote equal opportunity for all children to receive a high-quality education and attain proficiency (at a minimum) on challenging state achievement standards and state assessments. All children, including those with disabilities, are expected to meet the same standards and be assessed the same way. The law supports use of the same general curriculum for all children (K–12). It is the first law to mandate that the same assessment instruments be used for children with and without disabilities and that all results be reported. It also defines requirements for highly qualified teachers of core academic areas.

All preschool aged children do not yet have a federal right to public education. However, the majority of states offer state-funded, -controlled, and -supported preschool programs designed for children without disabilities but that can include young children with disabilities.

Legal Rights and Protections of Preschool Children with Disabilities and their Families

Children ages 3-5 with disabilities have the right to

- a free and appropriate public education (FAPE) with the supports each child needs to learn
- an Individualized Education Program (IEP) that includes goals, objectives, and intervention plans for the child to ensure the child's participation and enable him or her to progress in appropriate daily activities
- services without having a specific condition labeled. Eligibility is determined by IDEA criteria, but states are not required to report children with disabilities by disability category (Developmental delay is a broad category descriptor.)
- a statement of how the disability affects their involvement and participation in daily activities
- an education in least restrictive environment (LRE) with their nondisabled peers in the programs they would attend if they were not disabled
- a coordinated approach to service delivery in the least restrictive environment
- appropriate aids and supports to support their participation in appropriate daily activities
- the consideration of assistive technology devices and services to support positive outcomes

Parents or legal guardians of children with disabilities have the right to:

- all of the information necessary to make informed decisions about their child's education
- participate in the development of and approve all educational decisions about their child (Parents or guardians must agree with and sign the IEP.)
- an independent evaluation and a due process hearing if they contest the school's actions
- written notification in their native language of evaluations and IEP meetings
- confidentiality of their child's records and conversations about their child
- a copy of the procedural safeguards that ensure and protect the basic rights of children receiving special education and related services

Council for Exceptional Children Special Education Professional Ethical Principles

Instructions

Turnbull et al. (2016a) define the professional ethical principles for special education - these are important to be aware of and keep in mind as we discuss developing curriculum to support children with special needs in the early education classroom. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Ann Turnbull, Rud Turnbull, Michael L. Wehmeyer, and Karrie A. Shogren in *Exceptional Lives: Special Education in Today's Schools (8th).* 2016a

Professional special educators are guided by the Council for Exceptional Children (CEC) professional ethical principles, practice standards, and professional policies in ways that respect the diverse characteristics and needs of individuals with exceptionalities and their families.

They are committed to upholding and advancing the following principles:

1. Maintaining challenging expectations for individuals with exceptionalities to develop the highest possible learning outcomes and quality of life potential in ways that respect their dignity, culture, language, and background.
2. Maintaining a high level of professional competence and integrity and exercising professional judgment to benefit individuals with exceptionalities and their families.
3. Promoting meaningful and inclusive participation of individuals with exceptionalities in their schools and communities.
4. Practicing collegially with others who are providing services to individuals with exceptionalities.
5. Developing relationships with families based on mutual respect and actively involving families and individuals with exceptionalities in educational decision making.
6. Using evidence, instructional data, research, and professional knowledge to inform practice.
7. Protecting and supporting the physical and psychological safety of individuals with exceptionalities.
8. Neither engaging in nor tolerating any practice that harms individuals with exceptionalities.
9. Practicing within the professional ethics, standards, and policies of CEC; upholding laws, regulations, and policies that influence professional practice; and advocating improvements in the laws, regulations, and policies.
10. Advocating for professional conditions and resources that will improve learning outcomes of individuals with exceptionalities.
11. Engaging in the improvement of the profession through active participation in professional organizations.
12. Participating in the growth and dissemination of professional knowledge and skills.

Assessments for Functional Participation-Based IFSP/IEP Outcomes/Goals: A Practitioner’s Resource

Instructions

While this resource outlines Nebraska's policies and procedures, the laws that govern these rules are federal, so the recommendations here are applicable even here in California. This resource caught my eye because of the way the recommended practices were specified - they are good practice no matter where you are providing service. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Nebraska Department of Education & Health and Human Services, 2008

How can early childhood assessments be used to gather pertinent information related to a child's current and future participation in natural learning opportunities in their home, community and early childhood settings so that Individualized Family Service Plans (IFSP) or Individual Education Plans (IEP) lead to functional participation-based outcomes/goals?

How can this assessment process promote family/ caregiver participation so that they are equal partners in the development and implementation of a functional participation based IFSP/IEP?

Research Says...

Authentic assessments are "natural expressions of the functional capabilities of individual children observed in everyday settings and routines, using the ongoing natural observations of knowledgeable parents, teachers, and other caregivers" (Neisworth & Bagnato, 2004, p. 203). These authentic measures are most effective in making linkages between assessment and participation-based outcomes/goals and matching the recommended professional standards of the early childhood intervention fields (Bredekamp & Copple, 1997; Sandall, Hemmeter, Smith, & McLean, 2005). Conventional, norm-referenced tests are only useful in determining a child's degree of difference from typical development and offer little guidance to what specific behaviors or activities should be addressed in the intervention program or what special supports or services are appropriate (Neisworth & Bagnato, 2004).

Furthermore, we know that...

- Assessments should be conducted within contexts familiar to the child and with familiar materials; the child's authentic behaviors within typical routines provide the most useful information for planning intervention programs (Neisworth & Bagnato, 2004).
- Children will develop by being engaged in interactions with objects, people, ideas, and events that are familiar and of interest to them and their family (Jung, 2003).
- Both families and professionals are reliable and valid reporters of an individual child's development when using natural observations in everyday settings (Squires, Bricker, & Potter, 1998).

Assessments in Action

Early in the relationship with family members, try to define the family's or teacher/care-provider's current concerns, resources and supports through non-invasive questions. At first contact or during initial visits with the family or child's teachers or care-providers, you might ask:

- What are your concerns? What are your challenges in interacting with Kaleb?
- Tell me about the family and friends who help you with Kaleb.
- Tell me what you already know about that condition (diagnosis).
- What activities would like to see Kaleb enjoying in the next year?
- What communication have you had with Kaleb's parents about this concern?

- Who at your center or in the agency sometimes helps you with your concerns?

In addition, try and ask questions that identify child/family assets and child/family interests, such as:

- What are you and your child especially good at doing?
- What are your child's favorite toys, people, and events?

As this process continues and your relationship grows, use nonjudgmental, open-ended questions. Limit use of "yes/no" questions to clarify information provided, as they may imply judgment. For example:

- "Tell me how Ronnie plays with his friends."
- "How does Matthew communicate with you, so you know what he wants?" [to clarify:] "Does he get frustrated?"
- "You mentioned he has huge temper tantrums. What do those look like?"

Gather information about the child's participation in terms of independence, engagement, communication and social interactions within activities or routines. You could ask:

- At bath time, what does Sarah do? (engagement)
- During bath time, tell me what Sara is doing all by herself? (independence)
- How does Sarah communicate during bath time? (social communication)
- Are you satisfied with Sarah's participation in bath time? (expectation)
- How would you like it to look different? (possible priority)

When helping the team make a list of possible priority outcomes/goals, ask yourself or others these questions:

- Do some of these outcomes/goals need to happen before others can?
- Will this outcome/goal create change for child/family in many activities?
- Will the learning opportunity for this outcome/goal present itself frequently?
- Will this outcome/goal make the child more independent?
- Will this outcome/goal allow the family to do more things they would like to do?
- Will this outcome/goal make life easier for the family?
- Does this outcome/goal require "special" services/supports or simply increased learning opportunities?

Recommended Practices

The following recommended practices should be part of the early childhood assessment process. They are not intended to be role-, time-, or sequence-specific, except where there are legal requirements (i.e. Nebraska Department of Education (NDE) Rule 51, 2006; Individual with Disabilities Education Act (IDEA) 2006; Department of Health and Human Services (DHHS) Title 480 NAC 10-000, 2000). Each team should determine the assessment process they will use before they begin with each family so as to be assured of implementing best practice that can lead to the development and implementation of functional participation-based outcome/goals and interventions.

Child Evaluation

Team members should utilize evaluation procedures to determine if the child is eligible for special education services. These procedures have traditionally included standardized developmental or domain- specific instruments or non-standardized surveys, checklists or scales, and a review of records (i.e., Preschool Language Scale-4, Developmental Assessment of Young Children, Developmental Observation Checklist Screening, Vineland Adaptive Behavior Scales). The evaluation should include information about all areas of development (NDE Rule 51, sec. 006.02B9-10 and 006.02D2). Remember, “evaluation” in programs for children birth to age 5 refers to the process for determining program eligibility.

MDT Reporting

Prior to the IFSP/IEP meeting, the Multidisciplinary Evaluation Team (MDT) must share their information with the family and explain why the child is or is not eligible for special education services under NDE Rule 51. A copy of the MDT Evaluation Report, along with recommendations for eligibility, must be given to the parent (See NDE Rule 51, sec. 006.03 for legal requirements of the MDT).

Assessment-for-Program-Planning

The assessment-for-program-planning procedures are distinct from the evaluation process. They usually include observing a child in both structured and unstructured play with familiar toys/objects or participating in routine activities such as eating and dressing (Cook, 2004). The assessment should also include interviews about the child’s and family’s, care-provider’s, or teacher’s interests, daily routines, preferences, challenges, and priorities (McWilliam, 2005; Wilson, Mott, & Batman, 2004).

Assessment Tools

A variety of assessment methods can be used to gather information for functional outcome/goal and program planning. These can include checklists and the criterion-based assessment tools required for the local community’s accountability to Nebraska’s Results Matter (COR: HighScope Child Observation Record; CC-DC: Creative Curriculum Developmental Continuum; AEPS: Assessment, Evaluation & Programming System). In addition, using an asset- and interest-based approach to interviews and observations contributes information for the IFSP/IEP that will guide how children learn best and assure other positive benefits (Roberts, 2000; Swanson et al, 2006). Assessment for-program-planning should not be limited to standardized tools used for eligibility determination. In fact, assessment for these purposes should include the use of interview and authentic tools (i.e., COR, CC-DC, AEPS) which lend themselves to program planning that can minimize professional discipline boundaries and promote services in the context of a child’s natural learning opportunities (NDE Rule 51, sec. 008.01 and 008.03).

First Contacts

The assessment-for-program-planning should begin at first contact with a representative of the early childhood program/agency and can continue along with the evaluation process. This early contact sets the stage for the relationship between agency personnel and the family and should be in keeping with the goals and philosophy of the program. Initially, the family/caregivers should be given information about the evaluation/assessment process (i.e., rights and responsibilities, role of the caregiver in the process, why this information is gathered, how it is used, and whom it is shared with). Information gathering about the child (medical history, developmental abilities) and the family (resources, informal supports, concerns) starts here.

Family/Care-Provider Involvement

Prior to beginning the assessment-for-program-planning process, someone on the team should discuss options with the family for how the family, caregivers and teachers wish to be involved. In particular, these relevant adults should be encouraged to provide information about which activities will allow the child to show typical behaviors and/or challenges. All caregivers (parents/guardians, childcare providers, early childhood teachers) have valuable information to offer in order to capture the most accurate picture of the child and his/her needs and potential.

Conversations About Natural Learning Environments

Team members should utilize the information gathered during initial contacts to engage families in a conversation about the environments and activities where the child spends time, and with whom the child regularly interacts. To this end, the assessments should take place in natural environments and at times when team members can observe and interact with the child, family, and other care providers and assess the child's current level of participation in meaningful activities. If the child spends large amounts of time (i.e., > 4 hrs/day; > 12 hrs/ week) in multiple settings (e.g., home and childcare), assessments should occur in each of those settings. When possible, team members should perform assessments together... at the same time and in the same place to reflect the intent of interdisciplinary perspectives and efforts.

Assessment Report

Team members may choose to write an assessment report for the family and care providers. This easy-to-read report documents the observations, information, or strategies used during the assessment-for-program-planning process. Its purpose is to assist in developing the IFSP/IEP, and NOT to provide a narrative of the MDT evaluation results. The summary should contain child-specific examples, be positive and use people-first language. It should NOT contain jargon or focus on listing or describing a child's deficits (Alvarez, 1997). Assessment reports can be written to guide the discussions at IFSP/IEP meetings after an initial assessment, an annual review, or at the time of a child's transition to a new program (e.g., Part C to Part B program; to kindergarten; to a new community).

Sharing Assessment Information

Information from the assessment process should be shared with the family/care-providers in a manner that prepares them to participate in a collaborative and interactive IFSP/IEP meeting.

This may include an assessment report but should always include a face-to-face discussion of the major highlights with family members. The purpose of the discussion should be to allow family, care-providers and teachers to validate that the information gathered is representative of their child, and to help develop a list of possible priorities that are meaningful to them at home, or in classroom or community and will promote the child's participation in their natural and least restrictive learning environments. Team members who will be involved in the child's IFSP/IEP program planning should also have access to assessment information as well as any family priorities to be discussed at the IFSP/IEP meeting (Boone & Crais, 2002). This can be done prior to or early in the IFSP/IEP planning meeting.

Cyclical Process

The process of assessment-for-program-planning is ongoing and continuous and should be used for each and every IFSP/IEP meeting. Preparation for a subsequent IFSP/IEP begins upon first contacts with the child, family and care-providers and teachers following the initial IFSP/IEP meeting, with collection of information that may prove useful for determining future functional participation-based outcomes/goals.

Why Act Early?

Instructions

This resource defines early intervention and discusses why it is important to act early when there are signs of developmental delay. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Centers for Disease Control and Prevention. 2022b

Act early on developmental concerns to make a real difference for your child and you! If you're concerned about your child's development, don't wait. You know your child best.

Early intervention helps children improve their abilities and learn new skills. Take these steps to help your child today:

- Tell your child's doctor or nurse if you notice any signs of possible developmental delay and ask for a developmental screening.

If you or the doctor still feel worried,

1. Ask for a referral to a specialist, and
2. Call your state or territory's early intervention program to find out if your child can get services to help.

What is Early Intervention?

Early Intervention:

- Is the term used to describe services and support that help babies and toddlers (from birth to 3 years of age in most states/territories) with developmental delays or disabilities and their families.
- May include speech therapy, physical therapy, and other types of services based on the needs of the child and family.
- Can have a significant impact on a child's ability to learn new skills and increase their success in school and life.
- Programs are available in every state and territory. These services are provided for free or at a reduced cost for any child who meets the state's criteria for developmental delay.

Why Early Intervention is Important

Earlier is better!

Intervention is likely to be more effective when it is provided earlier in life rather than later.

"If it's autism, waiting for a child to 'catch up on his own' just won't work. Acting early can help a child communicate, play, and learn from the world now and for the future. It can also prevent frustration—so common in children with communication difficulties—from turning into more difficult behaviors." Pennsylvania clinical psychologist

The connections in a baby's brain are most adaptable in the first three years of life. These connections, also called neural circuits, are the foundation for learning, behavior, and health. Over time, these connections become harder to change.

“The earlier developmental delays are detected, and intervention begins, the greater the chance a young child has of achieving his or her best potential." Georgia pediatrician

Intervention works!

Early intervention services can change a child’s developmental path and improve outcomes for children, families, and communities.

“Acting early gives your child a chance to receive the appropriate therapy, giving him or her the best chance for a good outcome in the future. I believe that early intervention is the reason my high-functioning son is now able to blend in with his peers and attend kindergarten in a regular classroom with no supports." Kansas mom

Help your child, help your family!

Families benefit from early intervention by being able to better meet their children’s needs from an early age and throughout their lives.

“Action replaced fear and empowered me with the knowledge to help my son. He has overcome most of his symptoms and is headed to college next year." Florida mom

The Emotional Experience of Families of Children with Dis/abilities

Instructions

There are many emotions families move through as they go through the process to learn more about a child's special needs. Virtual Lab School (2021c) discusses the various steps families can move through as they learn the news about a potential disability and educate themselves about the process of finding resources and support. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Virtual Lab School, 2021c

Many families who have children with special needs or dis/abilities describe caregiving for their child as challenging yet extremely rewarding. Others feel as though caring for their child is no different than caring for any other child. Regardless of how families feel about their caregiving responsibilities, it’s important to recognize that they often have additional roles and responsibilities specific to their child’s needs. This can be extremely stressful for primary caregivers; it is important that you understand the impact on families’ stress and well-being. We must also consider the impact on the entire family unit and how roles may be re-defined compared to how we usually think about family members.

You've already learned about the importance of asking individual families for feedback on the language they prefer you use to discuss their child's dis/ability. For ease, you will see the terms "dis/ability" or "dis/abilities" used in this information. Having a "disability" is what allows children and adults in the United States to have access to certain rights and services (IDEA, 2004; ADA, 1990).

Dis/abilities affect individuals in different ways. Some people have dis/abilities that are life-long and will require care into adulthood; while others will learn and develop in ways that allow them to live independent lives or even "outgrow" a diagnosis. Dis/abilities can be visible or invisible and affect all of a person's ability to learn or impact just one specific learning area. You may see the term developmental delay used to describe a child's gap in development that is not linked to a specific diagnosis or condition or specific to development in early childhood (birth to six). For example, speech delays are common in young children with developmental delays, but many of these children catch up to their peers by the time they enter kindergarten.

Learning the News

The path for how one learns they are a parent, grandparent, sibling, or other family member to a child with a dis/ability is different for every family. We will use the term "primary caregiver(s)" to refer to the person(s) most central to a child's care. Primary caregivers are usually a child's mother, father, grandparent, relative, or foster parent.

You might see how some primary caregivers come to know that their child is developing differently from other children the same age. They may ask you questions about their child's behavior or development to learn if the differences they notice are typical. You may even be the one to first share concerns and recommend the family speak with a doctor or specialist. Though rare, there may be times in your work with children where you are devastated and shocked to learn that a child in your care has a serious condition or has been involved in a traumatic incident such as a car accident. Some families discover before their child is born or at birth that there is a risk of or that a child will be born with a condition. While it may seem as though families who have known about their child's dis/ability for some time have adjusted and are accepting of the situation, it's important to remember that every individual's emotional experience is different and is deeply impacted by their culture, relationships, and environment.

Emotional Responses to Dis/ability

Think about what it must be like to first learn that your child has a dis/ability. How would you react? Who would you turn to for support? Although rare, some families will not experience strong emotions and immediately embrace the situation. Others will be filled with a range of emotions and may react in ways that are not usual for them. Grief is included in the range of emotions often felt by primary caregivers. Grief is a deep feeling of sorrow, and we often think of it as what one feels after the death of a loved one. Most children with dis/abilities thrive but on rare occasions some children, despite a loving family and access to evidence-based intervention, are very slow to make minimal progress. These families may grieve for the child they thought they would have, but with time and support, they develop new hopes and dreams for their child.

Below are stages of grief that families with children with dis/abilities commonly experience. There is no specific order for these stages, nor do all families experience every single one of these emotions (The IRIS Center, 2008). Some families may feel these emotions on the inside but try to mask their feelings to others.

Denial: Families may not believe the news that their child has a specific condition or learning need. This can be especially true when the news is a surprise. An individual's culture, acceptance of people with dis/abilities, and knowledge of a specific condition can impact how one copes with the news. Those in denial may try to discredit the doctors or specialists involved in the process. Family members in denial may make statements about how their child, "never acts that way at home" or "that doctor doesn't know how to be around kids." This is especially true when the condition is based on a behavioral assessment rather than by an objective test such as bloodwork or genetic workup.

Guilt: Some families feel as though they did something wrong or are responsible for their child's dis/ability; as a result, these families can begin to question their past decisions. Families may feel as though professionals talk down to them or are critical of their decisions and parenting, which may increase any existing feelings of guilt. While professionals do not intentionally make families feel this way, be aware of your own biases towards families and their decisions. It can be difficult to hide your feelings and opinions when you communicate with families, but keep in mind that your role is to be supportive of their decisions.

Anger: Parents and caregivers may feel angry about their child's dis/ability. Some describe feeling as though it's not fair to their child or that they have bad luck. They may take their anger out on others. Remember that this anger may help families cope and eventually create plans for how to help their child in the future.

Depression: There is evidence to suggest that mothers of children with developmental dis/abilities are at increased risk for depressive symptoms due to the stress of parenting compared to parents of children without dis/abilities (Zeedyk & Blacker, 2017). While there is generally less research on fathers, some evidence suggests that those with children with dis/abilities also experience an increased risk of depression.

Anxiety: Once families begin to learn more about their child's dis/ability, worry can set in. Questions such as, "How am I going to go to work and take my child to all of these appointments?", "Will my child have a normal life?", and "Will my child be bullied or made fun of?" are common worries that families think about. Anxiety can make it difficult for people to move forward or make changes. Be thoughtful when making assumptions about primary caregivers who struggle to follow through with recommendations for their child. Lack of action or seeming uninterested doesn't mean they love their child less or are any less involved as caregiver. Anxiety can be crippling; it can prevent individuals from being able to move forward or make adjustments.

Bargaining: This is the stage of magical thinking and unrealistic expectations. Primary caregivers may think that if they work hard enough to help their child, they will be rewarded by having their child "cured" or that symptoms of their child's dis/ability will go away. Primary

caregivers may expect program staff to provide for their child in ways that are out of the scope of practice for childcare settings or are unrealistic given the program's adult-to-child ratio.

Fear: Parents of children who have a lot of medical needs may fear for their child's life or fear that other caregivers will not know how to keep their child safe. Some primary caregivers fear that no one will love and care for their child the way they do. If a primary caregiver of a child with a dis/ability seems critical of your care for their child, know that fear may be the root cause of such behavior or beliefs.

Other Roles

Primary caregivers often feel as though they take on extra roles when parenting a child with a dis/ability. Consider these roles and reflect on how these responsibilities impact the well-being of primary caregivers. Also think about how you can partner with the primary caregiver to help ease the stress of additional roles.

Advocate: Ensures the child has full access to rights and services on behalf of the child

Case Manager: Coordinates all care, appointments, specialists, doctors, and teachers, informs all parties of updates and important information

Expert: Has a wide scope of understanding about a specific diagnosis or condition and is available to answer questions and provide assistance to others when issues arise

Trainer: Responsible for training professionals and caregivers how to properly carry out a recommendation or task for the child

Financial Planner: Researches and coordinates long-term care plans to ensure the child will maintain quality of life when primary caregivers can no longer continue their roles

Impact on the Family

As you reflect on the emotional experience and many roles of primary caregivers of children with dis/abilities, think about the impact on the entire family.

Siblings, especially as they become youth, will sometimes take on caregiving-like tasks and roles. Some siblings of children with dis/abilities will thrive in this role and feel a sense of pride. Other siblings may feel jealous of or annoyed toward the sibling with a dis/ability, especially when the family's schedule and priorities seem to be made around caring for the other child. Primary caregivers may feel like so much of their time goes to caring for their child with a dis/ability that they don't get to give individual attention to their other children. If siblings are close in age, they may not have a "playmate" relationship that primary caregivers often think of if they planned the spacing of their children.

When children have more than one primary caregiver, much thought and energy is used to make decisions about shared responsibilities. This is true for all families that have more than one primary caregiver but can be especially stressful for families with a child with a dis/ability. Whether the individual's co-caregiving are marital partners, mother and daughter, or any other

arrangement, they may not have planned for the additional tasks and time needed to care for their child. Some families may have additional caregiving needs and may have a relative or babysitter that is very involved in supporting the family who may not have otherwise been needed if they did not have a child with dis/ability.

Due to the diverse cultural views on dis/ability, some core families choose to not share with extended family and friends that their child has a dis/ability. They may feel shame or unsure of how others will react. Some may fear that important people in their lives will be unaccepting of their child with a dis/ability. Among families who are open with others about their child's dis/ability, how much and what information they share varies. It can be difficult for primary caregivers who are in various stages of grief or have grown their acceptance to hear opinions and answer questions about their child. For example, a father who has learned to embrace that his daughter has autism may have a brother and sister-in-law who don't believe "girls can get autism" and that their brother needs to show his daughter "who is in charge of the family." This can create rifts within families that disrupt support systems and relationships.

Families with children with dis/abilities may feel they cannot take part in community activities. Some caregivers feel embarrassed about their child's development when in public or feel the need to apologize or explain for their child. Seeing children who are typically developing and of a similar age to their child can be emotional, especially as those children reach expected milestones that their child with a dis/ability is delayed in developing. This can re-trigger the various stages of grief discussed above.

References

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Teaching Dispositions for Early Education Special Needs Practitioners

Instructions

The CDE (2013) includes a list of dispositions for special education teachers - things to keep in mind and reflect on as you learn more about the field and consider whether or not to work with this special population. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original

response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By the California Department of Education in *Special Needs and Inclusion.* 2013

Seeking to promote the importance of creating inclusive early care and education settings, the Special Needs and Inclusion competency area addresses the knowledge and skills that early childhood educators are expected to have to foster the learning and development of young children with disabilities or other special needs. It includes policies and requirements for inclusive practice, program philosophies that promote full participation by all children, collaboration with families and other service providers, and personalization of practices to meet children's individual and family needs (CDE 2009b). Because children learn and develop in different ways, it is the responsibility of early childhood educators to provide diverse learning opportunities to meet the needs of all children. This competency area reinforces and extends the performance areas of the Observation, Screening, Assessment, and Documentation competency area.

Key Concepts

- All high-quality early education settings support the development, learning, and sense of belonging of young children with disabilities or other special needs and their families.
- Children are more alike than different and follow unique developmental paths.
- Early relationships with adults and peers are essential for the developmental and learning of all children.
- Collaboration among families, early childhood educators, early childhood special educators, and other service providers promotes the optimal development of children with disabilities or other special needs and supports their full participation in all types of early care and education settings.

Desired Outcomes for Practitioners and for Children.

- Values inclusions of all children as full participants in early care and education settings.
- Values collaboration with families, early childhood special educators, and other service providers in meeting the needs of children with disabilities or other special needs.
- Values access to the least restrictive environment.
- Is committed to creating inclusive environments that benefit all children in early care and education settings.

Desired Outcomes for Practitioners

If I have these dispositions, then I will...

- see concrete things I can do to support and ensure the child's right to play.
- balance compassion and "point of view" with the reality of the child's experience and development.

- maintain self-care opportunities for staff and myself.
- become an advocate, supporting and allowing specialists to take responsibility.

Desired Outcomes for Children

If teachers and caregivers have these dispositions, then children will...

- feel good about themselves and their abilities.
- have friends and get play and exercise each day.
- count on their teachers and families to help them when they need it.
- know that their teachers and caregivers are "on their side".
- speak up for themselves and their friends.

Working with Families of Children with Special Needs Lecture

By Elisabeth Fuller, 2022q

Families of Young Children with Special Needs

Preschoolers with special needs are members of our communities, programs, and families and it is our responsibility to provide high-quality, inclusive support for these children and their families. While these families often experience additional situations and stressors, they have hopes, dreams, and concerns for their children just like other families. You can positively impact families with a preschooler with special needs by empowering them with knowledge, empathizing with their feelings, and collaborating with other support professionals in their lives.

Working with Families of Children with Special Needs

Establishing meaningful relationships with families is a critical part of your work, and your communication is especially important when working with families with preschoolers with special needs. Some preschool children will enter your program with known special needs, and other families will learn that their child has a disability or is delayed while enrolled in your program. Families with eligible preschool-age children may receive special education services and have an individualized education program (IEP). Others may only receive support from a medical center, and some families will be involved with multiple systems of support. Regardless, families can be overwhelmed by what feels like a constant flow of suggestions and appointments to help their children learn and develop. These families may need more help supporting their children and may turn to you, or others in your program, for assistance with connecting to services or agencies outside of your program. It may be helpful to form relationships with outside agencies so you, or trainers and administrators in your program, have up-to-date information on how to make a referral and the types of services offered. Positive interactions with families and other professionals can decrease families' stress and improve their well-being.

Families with preschoolers with special needs may go through various evaluation processes and may ask you to complete questionnaires or provide input at the request of a doctor,

specialist, or teacher. Other professionals rely on this input, especially when they have limited amounts of time with children compared to program staff who often spend many hours each week caring for, educating, and observing children. This information can be used to determine if a child has a specific condition, support the child outcomes summary (COS) process, determine eligibility for specific services, and develop goals for an individualized education program (IEP). You, or a trainer or administrator from your program, may be asked to participate in an IEP review, a time when the team of professionals and families come together to assess progress, create new outcomes, and determine needed services. Preschool children with IEPs may attend your program and their local education agency (LEA). Services on an IEP may only be provided at the LEA, or interventionists and related services personnel may “push in” and provide services within your program. Regardless of how special education services are delivered, working with professionals from outside agencies helps things run smoothly for families and ensures that all of the professionals and caregivers in a child’s life are communicating. This lessens family stress by reducing the need for primary caregivers to act as the in-between messenger of important information.

Effective Practices

The first step to establish strong relationships with families of children with special needs is to spend time discovering their wishes and concerns for their children and to learn about the meaningful activities they participate in at home. Maintaining this communication throughout a child’s time in your program is essential. Ask questions to learn about strategies that work at home and consider using them in your classroom. Through your interactions you can build trust so both you and families feel comfortable sharing children’s strengths and if there are concerns (Sandall, Hemmeter, Smith, & MCLean, 2005). Before communicating concerns with families, it may be helpful to discuss with a coach, trainer, or administrator your plan to share this information using family-centered practice. Be prepared for families to react in a variety of ways, and know how you can offer support if they choose to take specific steps or access other agencies and resources. For families already receiving support from other professionals, ongoing communication with both families and professionals is critical to maintain consistency between program and home environments. When all the caregivers and professionals in a child’s life are consistently using effective strategies to promote development and outcomes, children are more likely to benefit and learn new skills.

In your collaboration with families, acknowledge and respect their strengths and unique background, while realizing their ability to make decisions that are right for them (Hanson & Lynch, 2004). This means that when family wishes and decisions are different from what you would recommend, you will respond to the family’s decisions with respect. Ultimately, meaningful communication and relationship-building will enrich the process for both yourself and families.

Take a look at the following guidelines that reflect family-centered practice. You may remember some of these from Lesson 1. Then, think about which of these you can use in your work with families of children with special needs (Turnbull, Turbiville, & Turnbull, 2000):

- Recognizing the family as a constant in the child's life; caregivers and service systems may come and go
- Facilitating collaboration between families and professionals
- Honoring and respecting family diversity in all dimensions (cultural, racial, ethnic, linguistic, spiritual, and socioeconomic)
- Recognizing family strengths and the different approaches that families may use to cope
- Sharing unbiased and honest information with family members on an ongoing basis
- Encouraging family-to-family support and networking
- Acknowledging and incorporating the developmental needs of the child and other family members into your practice
- Designing and implementing services that are accessible, culturally and linguistically respectful and responsive, flexible, and based on family-identified needs

There are many ways you can demonstrate respect and consideration for families of children with special needs in your classroom. Consider the following:

- Acknowledge that families know their child best and ask them questions about services or resources that may be helpful to you.
- Establish ongoing communication between home and school. Communication journals are a great way to maintain communication. These are usually sent home with the child and returned the next day. Teachers can share noteworthy observations or events, and families can respond to those or share their own news or reflections. While communication journals can be used with families of all children in your classroom, they can be an especially valuable tool in establishing consistency between home and school environments for children with special needs.
- Incorporate children's books in your classroom library that reflect consideration of multiple abilities and differences.
- Invite families to talk about their children with special needs. For example, a family member may come in your classroom and talk about their child's use of adaptive equipment (e.g., braces, wheelchair, or a communication device). The family member may explain the use of equipment, which can help children and other families understand aspects of their life. This also promotes acceptance of differences.
- Be a team player! Work collaboratively with families and other professionals who may be involved in the delivery of services to children with special needs.

If disagreements or miscommunication arise, consider the following:

- Remind yourself that your role is to support families' hopes and dreams for their child.
- Be patient. Dealing with a child with special needs may be challenging at times, and family members need time to navigate this experience at their own pace.
- Avoid making judgments for families and their children.
- Consider difficult times as opportunities to build trust between yourself and families.
- Question your assumptions about working with families of children with special needs and urge other professionals you know to do the same.
- Talk with your trainer, supervisor, or coach when in doubt about any aspect of your work with families.

Here are some useful resources (not required for the module this week, just for your information).

Resources for Families and Professionals

Beach Center on Disability https://beachcenter.lsi.ku.edu/

Be sure to look at the following sections in the website:

- Families & Partnership https://beachcenter.lsi.ku.edu/beach-families

Family Voices http://www.familyvoices.org/

- Family Voices aims to achieve family-centered care for all children and youth with special health care needs and/or disabilities.

Federation for Children with Special Needs https://fcsn.org/

- The website offers a variety of resources and services for families and other individuals who support family-centered practice.

Kids Together, Inc. http://www.kidstogether.org/

Be sure to look at the following sections in the website:

- Be an Includer
- Perspectives
- The Parent Side
- Building Community
- Vision Building
- Agencies and Organizations

Partnering with Families of Children with Special Needs

Instructions

Ray, Pewitt-Kinder, and George (2009) outline the stages families often go through as they move through the special needs process. They also discuss the IFSP/IEP process and strategies for working with families of children with special needs. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Julie A. Ray, Julia Pewitt-Kinder, and Suzanne George. 2009

> “There’s no good way to tell you. Your baby has Down syndrome,” said the pediatrician. My world instantly stopped, and I felt a black fog closing in. I couldn’t move or breathe or speak. The only sound I heard was my husband sobbing. My first thoughts were “No, I can’t do this. How do we go from expecting a perfectly healthy baby to receiving a stranger?” Finding out that our daughter Ella had Down syndrome was like being told that the baby we dreamed of had died and now we had a child we knew absolutely nothing about.
>
> —Baby Ella’s Mother (One of the Authors)

Families may learn their child has a disability during pregnancy, at birth (as baby Ella’s parents did), or even later, when their child enters a childcare program in a home or classroom setting. Although a family’s reaction to the news that their child has a special need may depend upon the child’s age, the severity of the disability, and the family’s cultural view of disabilities (Muscott 2002), researchers liken the experience to the grieving process that Kubler-Ross (1969) describes in her classic book, On Death and Dying. Reactions move from denial of the disability to anger at the diagnosis, to bargaining with the experts involved in the diagnosis, depression, and to acceptance of the disability. Acceptance of the diagnosis can take years, as frequent reminders of the disability cause families to reexperience the grief. For example, one parent said, “Grief may hit you when you least expect it—during a Christmas shopping trip... when you buy baby toys for a 9-year-old” (Naseef 2001, 207).

Stages of Adjustment

Some parents criticize this “grief” view of adjustment to a disability as being patronizing and not fitting their experiences. Ulrich and Bauer (2003) propose instead that the adjustment experience occurs in four levels as parents gradually become aware of the impact of their child’s disability. These levels include the following:

1. The ostrich phase. Parents do not deny a disability but do not fully realize its impact. For example, a parent may say, “He’s all boy. He just doesn’t like to sit still and read a book.”
2. Special designation. Parents begin to realize that their child has a special need and seek help or ask for special services.
3. Normalization. Parents try to make the differences between their child and children without disabilities less apparent and may actually request a decrease in services and more regular classroom time.
4. Self-actualization. Parents do not view being different as better or worse, just different. They support their child in learning about his or her disability, including how to be a self-advocate.

As an educator, you may find that it is not as important to classify families by stages of adjustment to the child’s disability as it is to understand that families have varied reactions and may work through their feelings in a different way and pace. It is helpful to realize that you and the family may not be operating at the same level or stage of understanding about the child rather than to make comments like “That family is so demanding” or “If the dad would get over his anger, we would be able to work together better” (Ulrich & Bauer 2003, 20). Listening to

families is key in working with them as partners in supporting the learning and development of their child with special needs. Unless you have a child with a disability, you cannot fully understand the experience.

As you get to know the child and family, it is also important to learn about and participate in the development of the child's Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP).

IFSP and IEP Services

Some early childhood teachers may feel overwhelmed and unprepared to have a child with special needs in their care. However, it is imperative that they learn about the special education process so they can support families in the myriad decisions they will face about their child's education. The Individuals with Disabilities Education Act (IDEA) of 2004 ensures early intervention, special education, and related services for more than 6.5 million infants, toddlers, children, and youths with special needs (U.S. Department of Education 2009). A child younger than age 3 can receive early intervention services in the home or childcare setting through an Individualized Family Service Plan developed specifically for the child by a team that may include therapists, early intervention specialists, teachers, caregivers, and parents. For children with special needs age 3 or older, the local school system develops and administers an Individualized Education Program.

Individualized Family Service Plan (IFSP) ***Birth through age 2***	**Individualized Education Plan (IEP)** ***Ages 3 through 21 years***
Focuses on the family and parents' role in supporting the child's learning and development	Focuses on the child
Outcomes focus not only on the child, but on the family	Outcomes focus on the child
Includes the concept of natural environments as places where learning occurs, such as at home, in childcare, outdoors in parks, and so on (services may be provided in the home)	Focuses on school and classroom environments, with services provided in the school setting
Involves many agencies in providing services because of the child's age; the IFSP integrates the services	Assigns the local school district to manage the child's services

Names a service coordinator, who assists the family in carrying out the plan	Authorizes the local school district to coordinate the program
Involves an initial meeting with the family to offer information and resources and to define the various agencies' roles and financial responsibility	Involves a meeting with the family to develop long-term and short-term goals for the child, accommodations and modifications, services, and child placement
Typically includes a meeting with the family every six months	Typically includes a meeting once a year

Both the IFSP and the IEP state the goals and objectives for the child's developmental and educational progress. This plan or program also specifies who delivers the services, such as speech or occupational therapists, how the child's progress is assessed, and if any special classroom placements are needed. The parents' agreement with all the plans in an IFSP or IEP is required.

Educators and families both benefit in understanding the key differences between an IFSP and an IEP (see "ISFP and IEP Key Differences"). Although there are some common themes between the IFSP and the IEP, the differences focus on two main areas. In an IFSP, the concept of providing services in natural environments, such as the home or childcare setting, is an important component. In an IEP, the school setting is typically where services are provided. Another major difference is the focus in an IFSP on the needs of not only the child, but also the family.

IDEA legislation requires the coordination of services from various agencies to avoid fragmented delivery of these services. In the child's first three years, a service coordinator assumes this responsibility, which may include any help needed for the family to function more effectively, such as food, shelter, health care, and education. When the child turns 3 and leaves the early intervention program, the service coordinator's role concludes. From age 3 through age 21, the local school district acts as coordinator.

Teachers and caregivers are important partners with families in the implementation of an IFSP or IEP. Families should be a part of the IFSP and IEP planning processes; educators can make sure this happens. For example, Ella's parents and all of Ella's caregivers and specialists attended and shared information during IFSP and IEP meetings, which gave a view of her development from several different perspectives. Educators facilitate the day–to-day environment in which the child participates, so it is essential to communicate with the family and other service providers, such as physical or developmental therapists, to know about and understand their recommendations for appropriate activities and materials to use with the child. For example, Ella's occupational therapist showed her preschool teacher how to help Ella hold pouring utensils, so she didn't soak herself at the classroom water table.

As an educator, helping to implement objectives and obtain outcomes for the child with special needs is a major role for you, as well as reporting child outcomes to the IFSP and IEP teams.

Also, asking family members questions to learn what you can about their child's specific abilities and needs is appropriate and helpful throughout the process.

Transition from the IFSP to the IEP

At age 3, children leave their state's early intervention program and move into the public-school system's early childhood special education program. This transition from the natural home or infant/toddler childcare setting to the typically more institutional classroom environment can be difficult and overwhelming for families, who must now learn about the IEP process and education laws, attend lengthy meetings, get acquainted with new therapists and school staff, and subject their child to new testing and evaluations.

As Ella's parents, we experienced a range of new emotions in this transition from the IFSP to the IEP. We felt sad, tired, concerned, angry, and surprised—

- "Overnight, our child went from a baby to a schoolgirl!"
- "The complexity of our schedule increased with meetings, paperwork, and travel to numerous therapy locations."
- "Our daughter would be exposed to illnesses in the classroom setting that she was protected from when receiving services at home."
- "Strangers were telling us what they thought was best for our daughter based on a test score and a single meeting."
- "We did not know we would have to fight for our daughter's rights."

Supportive caregivers and teachers can ease the stress of the transition from an IFSP to an IEP. Explaining families' rights and the procedures in the special education process and encouraging families to learn about the process is one way to provide support. Preparing families for an IEP meeting, typically once a year, by informing them of who will be there, what each person's role is, and what will happen in the meeting is also helpful. Let families know that they can bring advocates with them to this meeting.

Emphasize beforehand to the families their importance in the IEP meeting, and suggest they prepare and bring a list of their goals for their child. If needed, help them identify their concerns, family strengths, and priorities for their child. Encourage families to raise questions at the meeting about things they don't understand to make sure they agree with the IEP before they sign it (North Bay Regional Center 2008; PACER Center n.d.).

Strategies for Working with Families of Children with Disabilities

Families of children with special needs often have ideas from their perspective as parents about other ways educators can show support. Some collected suggestions focus on under- standing family life, learning about disabilities, communicating frequently, and working through challenges with families.

Understand Family Life

Appreciating and respecting the extra work it takes for families to care for and educate children with special needs is important. At the age of 3 months, Ella began a weekly schedule of six hours of physical, speech, developmental, music, and occupational therapies. She engaged in oral- motor exercises three times daily.

We taught all of Ella's caregivers how to feed, carry, and play with her. To accomplish the innumerable daily therapy goals, we kept lengthy, detailed checklists for separate caregivers. We asked caregivers to work on occupational therapy tasks such as having Ella pick up objects with clothespins and tongs or blow bubbles or suck drinks through thin straws to work on oral-motor (speech) therapy. All play activities were tailored to meet therapy objectives, as were the toys and books we purchased. Ella is now 5 years old, and our lives revolve around her therapies.

Our family's life is not unique in the strain that a child with special needs can place upon family time. Whether it is a therapy session, exercises, medical treatment done at home, or an unexpected hospital stay, there are extra demands for families of children with special needs. For working parents who cannot rearrange their daily schedule to fit therapies or doctors' appointments, difficult choices between their child's care and workplace requirements cause additional stress.

Supportive teachers and caregivers help ease parents' stress, whether it is implementing daily therapies or offering a sympathetic listener's ear. Some parents may not be aware of all the services needed to meet their child's needs or be able to afford them. Thus, informing families about resources in the community and how to access them is an important teacher contribution. For example, because of a mother's limited literacy abilities, one early childhood teacher helped her fill out the paperwork necessary to get home medical equipment for her preschool child with severe disabilities.

Learn About the Disability

As an educator, you may be familiar with a particular disability diagnosis, such as Down syndrome, but there is wide variation in its manifestations among children. Therefore, it is crucial to learn as much as you can about the individual child. The child's family may be the best resource for information, as well as the child's other teachers, caregivers, pediatricians, and therapists.

Borrow books and familiarize yourself with resources and free newsletters from national organizations. For example, the Council for Exceptional Children (CEC) Division of Early Childhood (DEC) offers several publications and professional development opportunities on the education and development of children with disabilities (www.dec-sped.org/About_DEC/Whats_New). Understanding a disability can help you better plan for the child's learning. Some of the families you work with may not have resources or knowledge about their child's disability, beyond their personal experience. Providing information that you've learned about the disability helps to support them.

Communicate Frequently with Families

As is true with families of all children, ongoing two-way communication between teachers and families is key in working successfully with families of children with disabilities. You can arrange a meeting with the child's parents prior to the child's start in your program or school. To get to know each other, find out as much as possible about the child and the family's goals for their child's learning and development, and tell parents how you design your program to meet individual children's needs. Provide a simple questionnaire for the family to specify important information about the child's likes, dis- likes, personality traits, skills, special health needs or medications, and emergency contacts. As one father advised, "The first thing is to listen to us… because we know our kids better than anybody" (Blue-Banning et al. 2004, 175).

Continue to stay in regular contact through formal and informal conferences, phone calls, notes, and e-mails. Keep a record of all communication with family members, including dates and the content of the communication. Do not hesitate to ask the parents questions or request advice about learning or behavior issues that arise during the day and if they have experienced similar incidents at home. For example, after working cooperatively with a family, a kindergarten teacher determined that the reason their daughter refused to come inside at the end of recess was because the ringing bell on the school wall was painful to hear, due to her sensory integration disorder. After the class lined up in a different location away from the bell, the child willingly joined her class in line.

In your communications as an educator, include positive comments about the child's successes and express your respect for the parents' efforts in helping their child develop as fully as possible. For non English-speaking families, obtain translation services through your school, other family members, or the community. Use graphics or icons to convey information in your written communication (Al-Hassan & Gardner 2002).

By using accurate terminology, educators gain the family's trust. When you convey your knowledge, compassion, and respect, such as by saying "a child who is deaf" instead of "a deaf child," you place the child as first and most important over the secondary concern, the disability. Avoid categorizing children in negative ways. Describing Marcus as a child who "has blue eyes, likes music, and has autism" frames the wholeness of the child in contrast to categorizing him as "an autistic kid."

It is disrespectful and trivializing to shorten the name of a disability by saying "a Downs child," for example. Even "a child with Downs" sounds as absurd as "a child with Cerebral." Educators should avoid making such references as "normal child" or "normal development" in discussions with families as well in professional dialogue. Such uses imply that children with special needs are abnormal; the correct terminology is a child with disabilities or a child with special needs and a child without disabilities.

As an educator, you need to avoid making generalizations about children with disabilities. Saying that all children with Down syndrome "are developmentally delayed" or "mentally retarded" is not accurate. Due to individual differences, improved health care, early intervention, and new methods of teaching, children with Down syndrome can meet the same developmental guidelines as children without disabilities. Although Ella has special needs in fine and gross motor development, she does not have a cognitive disability and at age 5 is ahead of her peers

in some developmental areas. It is important to learn about each child as an individual, beyond the label of “disability.”

Children with disabilities may have a variety of teachers, from their daily childcare provider or classroom teacher to a special educator, personal aide, or a speech, physical, or occupational therapist. Families may need help understanding how team-teaching works (Salend 2006), being confused possibly about who is their child’s real teacher. Educators’ communication efforts can help families learn about the different services their child receives.

When explaining early intervention and special education services, avoid educational jargon and acronyms like LD (learning disabled), BD (behavior disorder), EMH (educably mentally handicapped), OT (occupational therapy), and PT (physical therapy), or the names of tests like DIAL-3 (Developmental Indicators for the Assessment of Learning) or WISC-R (Wechsler Intelligence Scale for Children– Revised). These can be confusing to families and need to be fully explained.

Working with Challenging Situations

When working with families of children with special needs, you may encounter parents who appear angry, confrontational, mistrustful, or questioning about your teaching methods. Do not take this personally! Historically, families have had to be their own advocates for an appropriate education for their children with disabilities, and some families you are working with may have had negative experiences with the system in the past. They may have had to fight their medical insurance company for needed therapies or may have disagreed with school professionals about testing results or the best classroom placement for their child. Strive to listen to families, understand their point of view, and be patient. Avoid creating another adversarial experience for them, and work toward building a positive, collaborative relationship.

Conclusion

In your efforts to partner with families in their child’s learning and development, you are the expert in child development and education, but they are the experts in their child and the child’s disability. Be a teammate with families, and do not try to work alone in educating their child. Together, you and the family can help their child reach his or her full potential. Finally, don’t fear or worry about having a child with special needs in your classroom, center, or school. See the whole child, not just the hearing impairment, the cerebral palsy, or the autism. Remember, they are just kids!

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Tips for Childcare Providers to Communicate with Parents Their Concerns about a Child’s Development

Instructions

Since early education professionals are often the first to recognize a physical issue in a child's development, Childcare (2019d) outlines a few tips of what to look for when working with young children. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Childcare. 2019d

Childcare providers are in a unique position to notice if a child is not developing through typical stages or milestones. If there is a possibility that a child has a developmental delay, childcare providers have the responsibility to discuss their concerns with the child's family right away.

Children develop very quickly. If a child has a special need that affects her development, it is best ***not*** to take a "wait and see" approach. Getting professional help early for children can make a tremendous difference in their quality of life, their learning, and their later development. Sharing a concern about a child's development with a parent is never easy, but it can be an important way for childcare providers to ensure that children receive the early intervention they need.

Parents sometimes rely on childcare providers for professional advice. If a parent comes to you with a concern about a child's development, listen respectfully. Take a few days to watch the child and see if you observe the same issues. Share what you observe with the parent and discuss what to do next.

If you are the one who has concerns about a child's development and need to bring up a concern with a parent, show them the same respect. Explain your concerns gently. Encourage them to observe the child and allow them some time to see if they notice the things you are sharing with them.

Specific Tips for Communicating Concerns with Parents

Here are some suggestions for talking to parents about your concerns for a child's development:

- **Choose a time and place where you can talk alone.** Share your thoughts in person; this is not a conversation to have on the phone. If you are still responsible for children during this time, ask another adult to supervise them.
- **Make sure both you and the parents have enough time to talk.** This should not be done in a hurry as a parent is rushing out the door to work. You may want to schedule this conversation ahead of time. You might say, "Mary, I often have regular chats throughout the year with parents to get to know them better, talk about how their children are adjusting to childcare, or just general things we need to touch base on. It's time to schedule a chat with you. I wonder if you would have time this week to drop by in the afternoon?"

- **Be prepared for strong emotions.** Parents often sense there may be a problem but have been afraid to talk about it. Often, they may not know how to put their concerns into words. Sometimes they are not familiar with typical ages and stages and do not realize that some of their child's behavior is not typical. This is especially true for young parents who may not have other children. Parents also may be worried that if their child does have a special need, you will no longer want to provide childcare for their child.
- **Be caring, supportive, and respectful.** Some parents may be relieved to visit with you, but others may be defensive or scared. Showing warmth and respect will help parents trust and listen to what you have to share.
- **Begin by saying something positive about the child.** You might point out several things you really like about the child — his smile, curiosity, love of puzzles. Or you might mention something positive the child did recently such as helping a friend or learning a song. Say something positive about the child's relationship with the parent. When things go wrong, parents sometimes tend to blame themselves. Pointing out the positives helps reassure them that they are good parents. You might say, *"Mary, Sara seems to have a real interest in puzzles. She is so skilled at them. Tell me, have you worked with her on this? I can tell that you seem to have a real interest in helping Sara grow and develop."*
- **Ask if parents have concerns or questions about how the child seems to be developing.** Quietly and respectfully ask the parents to share what they have noticed. Who, what, when, where, how questions will help you gather more information and help parents focus on the issue. You might say, *"I wonder if you have had any concerns about Jason being able to understand what you say?"* Or *"Have you noticed if Sara seems to be having a hard time hearing loud noises or people talking? Tell me what you have noticed."* You might also say, *"How long has this been happening? When does this seem to happen? What happens next? Has anyone else noticed this? Where does this seem to happen most?"*
- **Share your own observations and concerns.** Do this only after the parents have had a chance to talk. Share information on typical developmental milestones or other developmental checklists so parents will have something to look at. If it makes you feel more comfortable, practice what you will say beforehand.
- **Choose your words carefully.** Rather than say, *"I think Sara might be deaf,"* give specific examples and describe what you have seen. You might say, *"I noticed the other day a gust of wind blew the door shut. It made a loud bang and scared all of us, but Sara didn't even flinch. And last week, I kept calling her to come to the lunch table and she didn't seem to hear me."*
- **Avoid using labels or technical terms.** Remember you are not trying to present yourself as an expert. It is not your job to identify the specific disability. It is a very scary thing for parents to hear that someone may think their child has a disability. Keep it simple. Use words that describe only what you have seen. You might say, *"I've noticed that Sara doesn't seem to hear loud sounds",* or "Jason *seems to bump into things a lot as if he has trouble seeing."* Or *"I miss hearing Megan babble and smile like she did when she was a baby."*
- **Keep your eye on the goal.** Your goal is to encourage the parents to get a professional evaluation for their child so that any concerns can be checked out. You might say, *"It*

never hurts to check things out. Think about how relieved you will be to find out for sure. And if it does turn out that there is a problem, getting help now will make a big difference."

- **Stress the importance of checking things out right away.** It is very common for parents to need a few days to think about and understand what you have shared. They often feel doubtful, confused, and scared. If they seem unable to take action, reassure them of your support. Remind parents that if there is a problem, getting help early can keep things from getting worse. Early help can make a big difference for a child's later development.
- **Be ready to offer information and resources.** Be prepared to guide the parents through the next steps to get an evaluation or help for the child. The first step usually is to have the child's doctor assess the situation. Your local school system should also be able to direct you to local services available to evaluate young children for developmental delays. Have contact information and website information on hand. If parents do not have access to the Internet, print off information and have it ready to share.
- **Continue your support.** When parents find out that their child has a disability, they may be in shock. Many parents go through a period of grieving. They may become depressed or angry. The range of emotions they experience may make it hard for them to complete everyday tasks. It is possible they may even consider removing the child from your care because they don't want to face the issue. Sometimes this happens. Continue to be understanding and to listen and offer help.
- **Trust yourself.** As someone who cares for children every day, you are in a unique position to notice when a child may be experiencing problems. Sharing your concerns respectfully with parents shows that you really care about their child. Even if a parent seems to resist your efforts at first, they will most likely be grateful later for your concern.

Module 3: Differing Abilities

Now that we have covered the larger issues related to special education, like laws and setting up the learning environment, we are moving into how to support children within the classroom. CHDV C141 defines exceptional needs more specifically, we will review the broader categories and then discuss how to adapt classroom materials, curriculum, and the environment to support children of all abilities. This is a difficult module because it is basically summarizing everything from CHDV C141 with the addition of strategies to support each disability. I have provided a lot of resources for specific disabilities for you to look through, most of them are short reads and won't take as much time as it looks like.

It is important to remember that while we can identify some general ways to support children with a variety of disabilities, each child is unique and needs to be supported in whatever way best meets their and their family's needs. It is through observation, interaction, and education that we are able to learn about each individual child and what they need to grow, learn, and thrive.

The 13 Disability Categories Under IDEA

Instructions

Lee (2023) outlines the 13 disability categories covered by IDEA; in case you haven't taken CHDV C141 yet where we covered these in more detail. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Andrew M.I. Lee, 2023

At a Glance

- The Individuals with Disabilities Education Act (IDEA) requires public schools to provide special education services to eligible students.
- IDEA covers 13 disability categories.
- Not every student who struggles in school qualifies.

The Individuals with Disabilities Education Act (IDEA) requires public schools to provide special education and related services to eligible students. But not every child who struggles in school qualifies. To be covered, a child's school performance must be "adversely affected" by a disability in one of the 13 categories below.

1. Specific Learning Disability (SLD)

The "specific learning disability" (SLD) category covers a specific group of learning challenges. These conditions affect a child's ability to read, write, listen, speak, reason, or do math. Here are some examples of what could fall into this category:

- Dyslexia
- Dyscalculia
- Written expression disorder (you may also hear this referred to as dysgraphia)

SLD is the most common category under IDEA. In the 2018–19 school year, around 33 percent of students who qualified did so under this category.

2. Other Health Impairment

The "other health impairment" category covers conditions that limit a child's strength, energy, or alertness. One example is ADHD, which impacts attention and executive function.

3. Autism Spectrum Disorder (ASD)

ASD is a developmental disability. It involves a wide range of symptoms, but it mainly affects a child's social and communication skills. It can also impact behavior.

4. Emotional Disturbance

Various mental health issues can fall under the "emotional disturbance" category. They may include anxiety disorder, schizophrenia, bipolar disorder, obsessive-compulsive disorder, and depression. (Some of these may also be covered under "other health impairment.")

5. Speech or Language Impairment

This category covers difficulties with speech or language. A common example is stuttering. Other examples are trouble pronouncing words or making sounds with the voice. It also covers language problems that make it hard for kids to understand words or express themselves.

6. Visual Impairment, Including Blindness

A child who has eyesight problems is considered to have a visual impairment. This category includes both partial sight and blindness. If eyewear can correct a vision problem, then it doesn't qualify.

7. Deafness

Kids with a diagnosis of deafness fall under this category. These are kids who can't hear most or all sounds, even with a hearing aid.

8. Hearing Impairment

The term "hearing impairment" refers to a hearing loss not covered by the definition of deafness. This type of loss can change over time. Being hard of hearing is not the same thing as having trouble with auditory or language processing.

9. Deaf-Blindness

Kids with a diagnosis of deaf-blindness have both severe hearing and vision loss. Their communication and other needs are so unique that programs for just the deaf or blind can't meet them.

10. Orthopedic Impairment

An orthopedic impairment is when kids lack function or ability in their bodies. An example is cerebral palsy.

11. Intellectual Disability

Kids with this type of disability have below-average intellectual ability. They may also have poor communication, self-care, and social skills. Down syndrome is one example of a condition that involves an intellectual disability.

12. Traumatic Brain Injury

This is a brain injury caused by an accident or some kind of physical force.

13. Multiple Disabilities

A child with multiple disabilities has more than one condition covered by IDEA. Having multiple issues creates educational needs that can't be met in a program designed for any one disability.

Learn More

Having a disability is not enough to qualify for special education. The disability has to have an "adverse effect" on a child's education. When kids are found eligible, the next step will be to create an Individualized Education Program (IEP). For kids who are in preschool or younger, you may want to learn about early intervention.

About Intellectual and Developmental Disabilities (IDDs)

Instructions

This resource provides an overview of IDDs and provides a note on why there might be differences in definitions of IDDs depending on what organization you are working with. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By National Institute of Child Health and Human Development. 2021

What are IDDs?

IDDs are differences that are usually present at birth and that uniquely affect the trajectory of the individual's physical, intellectual, and/or emotional development. Many of these conditions affect multiple body parts or systems.

Intellectual disability starts any time before a child turns 18 and is characterized by differences with both:

- Intellectual functioning or intelligence, which include the ability to learn, reason, problem solve, and other skills; and
- Adaptive behavior, which includes everyday social and life skills.

The term "developmental disabilities" is a broader category of often lifelong challenges that can be intellectual, physical, or both.

"IDD" is the term often used to describe situations in which intellectual disability and other disabilities are present.

It might be helpful to think about IDDs in terms of the body parts or systems they affect or how they occur. For example:

- **Nervous system.** These disorders affect how the brain, spinal cord, and nervous system function, which can affect intelligence and learning. These conditions can also cause other issues, such as behavioral disorders, speech or language difficulties, seizures, and trouble with movement. Cerebral palsy, Down syndrome, Fragile X syndrome, and autism spectrum disorders (ASDs) are examples of IDDs related to problems with the nervous system.
- **Sensory system.** These disorders affect the senses (sight, hearing, touch, taste, and smell) or how the brain processes or interprets information from the senses. Preterm infants and infants exposed to infections, such as cytomegalovirus, may have reduced function with their eyesight and/or hearing. In addition, being touched or held can be difficult for people with ASDs.

- **Metabolism.** These disorders affect how the body uses food and other materials for energy and growth. For example, how the body breaks down food during digestion is a metabolic process. Problems with these processes can upset the balance of materials available for the body to function properly. Too much of one thing, or too little of another can disrupt overall body and brain functions. Phenylketonuria (PKU) and congenital hypothyroidism are examples of metabolic conditions that can lead to IDDs.
- **Degenerative.** Individuals with degenerative disorders may seem or be typical at birth and may meet usual developmental milestones for a time, but then they experience disruptions in skills, abilities, and functions because of the condition. In some cases, the disorder may not be detected until the child is an adolescent or adult and starts to show symptoms or lose abilities. Some degenerative disorders result from other conditions, such as untreated problems of metabolism.

The exact definition of IDD, as well as the different types or categories of IDD, may vary depending on the source of the information.

For example, within the context of education and the Individuals with Disabilities Education Act (IDEA), a law that aims to ensure educational services to children with disabilities throughout the nation, the definition of IDD and the types of conditions that are considered IDD might be different from the definitions and categories used by the Social Security Administration (SSA) to provide services and support for those with disabilities. These definitions and categories might also be different from those used by healthcare providers and researchers.

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Early Intervention for Children with Intellectual Disabilities: An Update

Instructions

In Guralnick's (2015) comprehensive study about the importance of early intervention, I appreciate his conclusions about inclusive preschool settings and how they play an important role in all aspects of a child with IDD's development and learning. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Michael J. Guralnick. 2015

Preschool Inclusion

One setting in particular in which a certain level of structure is valuable and necessary is in preschool. It is the case that teacher child relationships similar to those described for parent child transactions create the type of environment conducive to promoting all aspects of a child's development, including specific pre-academic skills related to language and mathematics (e.g., Burchinal et al. 2008; Howes et al. 2013). In this context, information is periodically transmitted in a highly structured, didactic manner and organized by specific curricula.

A major question is whether children with delays not only benefit from preschool settings that are a unique combination of free-flowing and social interactions and structured formats but also can do so when participating with a large proportion of children who do not exhibit delays. Indeed, including children with delays in typical educational settings is part of a larger effort to support practices that maximize children's full participation in all community activities – social, recreational and educational. Although often difficult to implement, this human rights principle is now well accepted on many grounds (Guralnick 2001; Brown & Guralnick 2012; Bruder & Guralnick in press).

Many countries have established universal preschool education, and this movement is rapidly advancing in the United States. Universal preschool provides an opportunity for children with delays to take advantage of these inclusive settings but also raises the question as to whether high-quality inclusive preschool programs can meet their special needs in that context. Recent work has directly addressed this question focusing on the development of pre-academic skills of children with mild or moderate developmental delays enrolled in Tulsa, Oklahoma's high-quality universal preschool program. Initial results using a quasi-experimental design indicate that children with and without special needs make significant advances and at a similar pace with respect to early literacy (Phillips & Meloy 2012). Although additional efforts are needed to realize similar benefits in the domains of math readiness and problem-solving skills, these results suggest that access to universal preschool programs means that all children can benefit.

Accordingly, parents of children with delays should pursue this family-orchestrated child experience. Early intervention systems capable of coordinating other services and supports in conjunction with inclusive preschool programs that center on families and promote other aspects of family patterns of interaction will provide the type of comprehensive system essential to maximizing children's cognitive as well as their social competence.

Indeed, the need for efforts to promote the social competence of children with delays becomes even more evident in inclusive settings. Specifically, it has been well established that children with delays exhibit unusual difficulties in relating with peers and establishing friendships (Guralnick 1999, 2010). Despite the significance of this problem and its broad implications for children's quality of life now and in the future, only limited research has been conducted in recent years. The most comprehensive RCT to address the peer competence of children with delays focused on the organizational processes of social cognition and emotion regulation using play scripts as a critical intervention strategy. Over a 2-year period, interventions were carried out at home working with parents and in inclusive preschools working with teachers. All aspects of the intervention were guided by a developmental framework. Results were promising in that, especially for children with >IQs below 70, compared to the control group, intervention children displayed more positive responses to social bids by peers and the intervention prevented increases in a range of negative social interactions. Yet, other measures tapping core features of peer-related social competence did not differentiate the groups (Guralnick et al. 2006). As indicated in my previous review (Guralnick 2005), this important area has not received sufficient attention from researchers, a concern still evident today. Peer relationship issues are certain to become more apparent as preschool children with delays begin to participate even more frequently in inclusive settings as universal preschool programs as well as involvement in other community activities become more common.

Different Modifications for Students with Intellectual Disability for the Classroom or at Home

Instructions

These are modifications that can be made to support children with IDDs in any environment. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By BrightHub Education. 2022a

Children with intellectual disabilities need some additional support and modifications in their environment, as well as in the type of activities they do. Here are a few modifications for students with an intellectual disability that will help them to learn better.

Quiet Workspace

Children with intellectual disabilities tend to get distracted more easily and often struggle with attention. Ensure that the child has a work/ study space that is quiet and free from distractions. Using this space only for studying also will help the child get into a routine of studying and also understand that when he is sitting there, he is supposed to concentrate on the activity or task, and not play.

Children with intellectual disabilities learn better through functional day-to-day activities. Thus, instead of attempting to teach science theory or geography, it is better to teach practical things that will be useful, such as how to boil an egg or how to find their way to their friend's house.

Repetition of Concepts Over the Day

Children with intellectual disabilities need to learn a concept in different ways and have the opportunity to practice it many times in order to learn and remember it. Allow time, as well as opportunities, to practice the skills that you have taught them.

Teacher-Student Ratio

One major modification that needs to be considered for children with intellectual disabilities is the student-teacher ratio. These children require additional support and guidance as they work on their activities. Ideally, there should be at least 1 teacher for every 3 children with intellectual disabilities.

Hands on Learning

Children with intellectual disabilities learn a lot through doing tasks rather than just listening. Using all the senses to learn also helps them learn and retain information better. Your classroom or teaching area must have space and resources to allow children with an intellectual impairment to do various activities that are functional as well as academic.

Safety Measures

Safety issues need to be considered while planning a teaching space for children with an intellectual impairment. Sharp scissors, knives, etc. must be kept out of reach. Harmful liquids like cleaning liquids must also be kept away. Medicines must be kept out of reach. In addition to this, make sure that none of the children can lock themselves up in any room. Small beads or other toy parts that the children could put in their mouth must be kept away if a child has a tendency to do that. If the child has seizures, you may need to look at padding the corners of furniture to avoid injury.

Schedule

Children with intellectual disabilities find it hard to sit in one place and do an activity for a long time. The schedule must have short activity times and must alternate between physical and

sitting down activities. The schedule must also try and incorporate some aspects of self-care, so that children start becoming more independent in putting on or taking off shoes, going to the toilet, or feeding themselves.

These are some modifications for students with an intellectual disability that can be used in a classroom or home setting. A little effort can go a long way in helping children with intellectual disabilities stand on their own feet.

Effective Teaching Strategies for Students with Intellectual Disabilities

Instructions

BrightHub (2022b) has summarized a few strategies for working with children with IDDs. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By BrightHub Education. 2022b

Hands-On Learning

When we teach children with intellectual disabilities, we need to keep in mind several factors. First of all, we need to set goals that are most important for the child. Learning the names of the planets may not be as important as learning about how plants grow. Next, we need to make materials and set up the environment so that it supports the child's learning. Finally, we need to use some teaching strategies to teach and motivate the child to learn. Here we explore a few effective teaching strategies for students with intellectual disabilities.

Hands-on learning benefits students

Hands-on learning is the process of using activities and other hands-on tasks to teach skills. All children and especially children with intellectual impairments learn best through this process. An example would be to do science experiments to learn science concepts. Another idea is to use play dough and make letter shapes to learn letters. Hands-on learning is also a great way to learn math.

Play-Based Learning

Play-based learning is when we use play activities to teach cognitive skills. For example, if a child is playing with cars, we sit with the child and start playing too. While playing we use statements like “can I play with the red car? Can you give it to me?” In this way we teach skills to the child while he or she is playing.

Baby Steps

Children with intellectual disabilities need to learn through baby steps. Every task, skill or activity needs to be broken down into small baby steps. The child is taught one small step at a time. Slowly, he or she learns to combine these baby steps to learn a bigger concept. For example, we will not teach the concept of red color in one day, we will first teach sorting red, then matching red, then identifying red, then naming red and finally generalizing red. In this way try to break up every skill into small baby steps.

Chaining

Chaining is the process of breaking a task into its small steps and teaching students in a sequential manner. It is usually used to teach daily living skills and life skills. For example, we first teach a child to hold a pant with two hands, then we teach him to hold it and bring it down to his legs. Next, we teach him to hold it, bring it down to his legs, and put one leg inside. This process is called forward chaining. Backward chaining is when you teach the child the last step first. We do the activity of the child and let the child do the last step on his own. Then we do the

activity till the second last step. In this way the child does more and more of the activity, and we do less till the child can do the whole activity on his own.

Group Learning

Group learning is one of the most effective teaching strategies for students with intellectual disabilities. It is when you bring children together in a group to teach various skills. Children often do better when they are in a group. Behavior difficulties are less, and children motivate each other. The only difficulty in group learning is that you need enough hands to help children learn together.

Positive Reinforcement

Positive reinforcement is used to reinforce the child positively every time he learns a new skill or performs or practices a known skill. It is a great way to motivate children with intellectual disabilities. Use reinforcements that are appropriate for the child.

These are just a few effective teaching strategies for students with intellectual disabilities. The best way to teach, however, is to understand the child, understand his abilities and his needs. From there comes the natural selection of strategies and methods that fit him or her.

Sensory Impairments Lecture

By Elisabeth Fuller. 2022l

According to IDEA, there are three classifications of sensory impairments:

- **Blind or Visually Impaired**: Under IDEA, a visual impairment, including blindness, means "an impairment in vision that, even with correction, adversely affects a child's education performance. The term includes both partial sight and blindness" (IDEA, Sec. 300.8[c][13]).
- **Deaf or Hearing Impaired**: Under IDEA, the educational definition of deafness is "a hearing impairment that is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification, that adversely affects a child's educational performance" (IDEA, Sec. 300.8[c][3]). Under IDEA, a hearing impairment is "an impairment in hearing, whether permanent or fluctuating, that adversely affects a child's educational performance but that is not included under the definition of deafness in this section" (IDEA, Sec. 300.8[c][5]).
- **Deaf-Blind**: Under IDEA, "deaf-blindness means concomitant hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational needs that they cannot be accommodated in special education programs solely for children with deafness or children with blindness" (IDEA, Sec. 300.8[c][2]).

Impact on Learning

What is interesting, is that hearing and/or visual disabilities alone do not impact the cognitive development of children, but the mental processes required to learn new information differ for children with sensory impairments. So, the overall impact on learning is more a function of the lack of input than an inability to learn. This means that children with sensory impairments often have typical learning processes and modes, they just have difficulty accessing information because of the lack of sensory input. In order to qualify for special education services, the sensory impairment has to interfere with normal learning ability.

Children with sensory disabilities can have a wide variety of abilities, from no hearing/vision to low hearing/vision, to seeing dark objects or flashes of light, or hearing speech as white noise, to having no hearing nor vision (Deafblindness). Both deaf and blind children have a variety of adaptive equipment and assistive technology that can be used to support them in the classroom, however, these tools do not ensure access. It is the early educator that is responsible for ensuring a child's success in the classroom setting.

Since there is so much information about each sensory impairment, I've included lists of resources for hearing loss, vision loss, and deafblindness. You can peruse these or do your own research to learn more about sensory impairments.

The Importance of Play

While all disabilities have the potential to affect children's ability to engage in play and use play as an avenue for learning new skills and/or concepts, the sensory impairments have a much more profound effect and play skills need to be specifically taught to children with sensory impairments. The issues children with sensory impairments may experience include orientation, a lack of exploratory and imitative skills, lack of understanding of use of materials, inability to respond or react to other children's initiations for play, in understanding and being understood, and the ability to describe, extend, or control play with others. The lack of responsiveness from a child who cannot see, hear, or either see and hear (Deafblindness) can limit object play as well as social play. For this reason, children with sensory impairments need focused attention and support in learning how to connect, communicate, and play with other children in the classroom. I've included a list of resources that give information about the importance of supporting and teaching children with sensory disabilities how to play and also resources that include strategies, modifications, and adaptations to support children's play.

Modifications for Sensory Impairments

Instructions

Here are some suggestions for modifying teaching strategies and everyday activities so all children, but especially those with sensory impairments, can participate in an inclusive early childhood setting. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Mary Jo Noonan and Linda McCormick in *Teaching Young Children with Disabilities in Natural Environments*. 2013

For Children with Mild-to-Moderate Hearing Impairment

Seat the child in front of the speaker in circle activities: Placing the child near the speaker maximizes hearing and helps the child read speech and see facial expressions.

Speak in a normal teaching voice: Don't speak louder than you normally would. Instead, use natural gestures and visuals such as photos, symbols, and objects to supplement your oral presentations.

Speak the child's name when addressing them: Wait until the child is looking at you before speaking.

Indicate what you're referring to: When you're referring to someone or something in the classroom environment, touch, point, or nod in the direction of the referent.

Don't stand in front of a strong light source when speaking to the child: The child will miss important visual cues when your face is in the dark.

Teach peers attention-getting techniques and remind them to speak one at a time and to look at the child when addressing them. Even preschoolers learn very quickly to touch the student lightly on the shoulder and look them in the face while talking.

Learn and use as many signs as possible: If the child signs, learn and use functional signs such as "all finished," "sit," and "toilet." Encourage peers without disabilities to use them, too.

For Children with Visual Impairments

Give verbal cues to let the child know what's going to happen next. For example, "Do you smell the orange juice? I'm going to put the juice cup in your hand now. It's half full of orange juice."

Provide physical cues about how to carry out a task or activity. For example, gently guide the child to the housekeeping center. Place one of their hands on a bowl and put a spoon in the other hand.

Label actions and objects as they are occurring. For example, "We are putting the art materials away so we can get ready to go outside."

Encourage exploration and manipulation of all parts of an object. It's important for the child to understand the relationship of the parts of the object to the whole.

Let the child know where you are. Keep the child informed of your physical location in the classroom. For example, say: "I'm leaving the block area now to go get ready for snacks. Peter and Taylor are still here to build blocks with you."

Help the child make connections between events. For example, “When that bell rings, it’s almost time to go home—you hear everyone hurrying to put away their materials and get their coats. Then we all stand in line by the door.”

Give detailed verbal directions and explanations. For example, “After you find your cubby and put away your backpack, walk over to the nearest table and sit down. Ms. Rice will have some of your favorite toys there and you can choose what you want to play with.”

Show peers how to be friends and helpers. Teach peers how to helpfully identify themselves: “It’s me, Timmy. I’ll pull out the chair for you if you want to sit here.”

Physical Disabilities and Health Problems Lecture

By Elisabeth Fuller. 2022k

The special education category of physical disabilities and health problems is the widest category with the most differences in how these issues present in children. Some children have no restrictions on what they can do and learn, while other children can be extremely limited and may require medical and educational assistance. While there may be physical deficits in gross and fine motor skill development, including speech and communication issues, children could be functioning intellectually at a normal or even gifted level. Some children may have extremely debilitating physical disabilities that result in low intellectual functioning. For this reason, the assessments, accommodations, and modifications are varied and based on the needs of the child - which can change over time as they grow and develop. In order to qualify for special education services, a child must meet two conditions:

1. limited strength, vitality, or alertness due to chronic health problems or a physical disability; and
2. an educational performance that is negatively affected as a result.

Whether a child qualifies for services or not, the main issue children with physical disabilities and health impairments have is actually accessing the learning environment. This is when Universal Design for Learning (UDL) is especially important (discussed in Module 1). These children may require extra time to complete tasks, may become fatigued easily due to the greater amount of energy needed to complete daily tasks, may be absent regularly, may have difficulty concentrating for longer periods of time, and may feel excluded if they have difficulty moving around the classroom.

One of the key considerations when working with children with physical disabilities and health impairments is how they are handled and positioned. Early educators may need special training to learn how to pick up, carry, hold, and assist a young child. It is important to be able to position a child to support the child's body and arrange instructional and play materials in the most conducive and comfortable way for the child. Proper positioning and handling allow the child to participate in the classroom efficiently and effectively for their physical conditions.

Physical Disabilities and Childcare

Instructions

Childcare (2019a) provides overview information about physical disabilities. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Childcare. 2019a

Childcare providers can play a valuable role in supporting the healthy development and learning of children with physical disabilities. Young children learn about the world by interacting with their environment. Children with a physical disability may have more challenges in interacting with the world and discovering new things.

A physical disability is anything that limits the physical function of the child's body. Physical disabilities can include challenges with large motor skills like walking, or small motor skills like holding objects and using scissors. A child may also have a medical disability that limits her ability to be physically active, such as a heart or breathing issue. Physical disabilities may be present from birth or may develop at any point during a person's lifetime.

Some children may come to childcare with their physical disability already diagnosed. Other physical disabilities may become more obvious as the child grows and attempts to do new things.

Childcare providers may be the first ones to recognize signs of a physical disability in a young child and should share those concerns with the child's parents. If you notice that a child in your care seems to be struggling with motor skills, share your concerns with the parents.

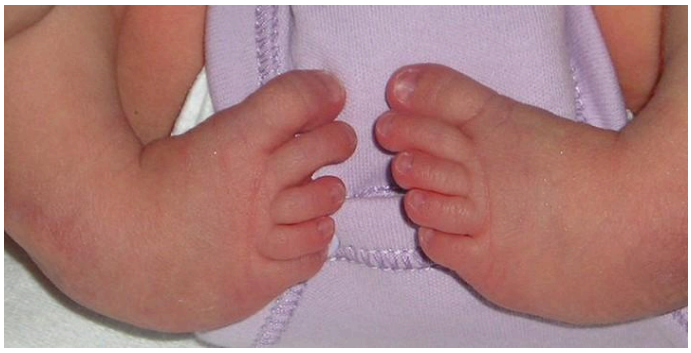
Physical Disabilities: Signs of Concern

Instructions

Childcare (2019b) highlights what early education professionals should be aware of when working with young children. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Childcare. 2019b



Childcare providers are in a good position to recognize problems or delays in young children's physical and motor development. As they work with children, childcare providers should observe their developing physical and motor skills. Pay close attention to a child who does not seems to be progressing through the typical motor developmental milestones — such as holding up the head, rolling over, sitting, standing, walking, and running — at about the same time as other children in the childcare program.

It's important to remember that physical development is a long process, and even typically developing children acquire new skills at different times. Some infants walk as early as 9 or 10 months. Others do not walk until 16 or 17 months. Also keep in mind that crawling is not a universal developmental milestone. Although most infants crawl on hands and knees, some may scoot or crawl on their bellies or may roll to move around.

Signs That May Suggest a Physical Disability

When children miss important physical and motor milestones, they may be showing early signs of a developmental delay or physical disability. The following are typical signs that may suggest a physical disability or motor delay. Childcare providers should pay attention if a young child:

- has unusually tight muscle tone and resists sitting up or bending the knees.
- has unusually loose muscle tone and cannot hold his head up after about 3 months.
- does not reach for toys.
- has trouble releasing objects voluntarily.
- does not reach across the body during play.
- reaches only with one hand, even when feeding himself.
- doesn't put hands out to catch himself if falling.
- has poorly developed hand or finger coordination and cannot pick up or hold objects.
- has poor balance or stumbles and trips frequently.

If you suspect that a child may have a physical or motor delay, observe carefully for several days. Make note of what the child can do well and where she is having difficulty. Share your concerns with parents. If the child appears to be delayed in developing certain physical skills, you might recommend that parents take the child to be screened.

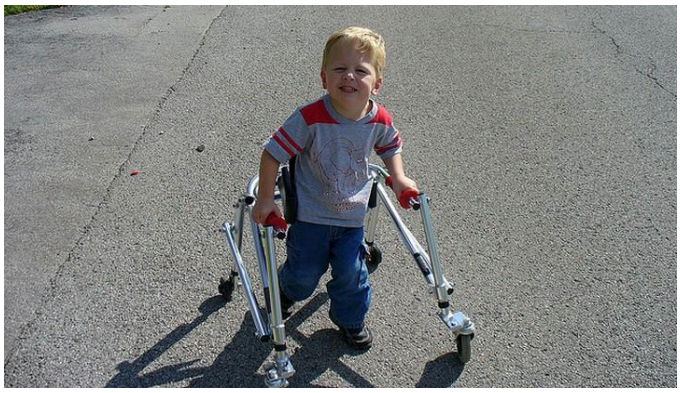
Specific Ideas for Childcare Providers to Help Children with Physical Disabilities

Instructions

Childcare (2019c) provides information on how to help children develop their self-confidence and independence. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Childcare. 2019c



Working with children who have physical disabilities requires thoughtful planning for childcare providers. Children with physical disabilities need different types and amounts of assistance and support in order to participate fully in their childcare program. Childcare providers who are including a child with a physical disability need to get input from the parents, professionals working with the child, and the child himself or herself. That input can help the childcare provider make specific plans to accommodate the child in the childcare program.

Helping Children Be Independent

Children with physical disabilities are children first. Like all children, they need opportunities to make choices and do things for themselves, within the limits of their ability. Resist the temptation to do everything for the child. Provide appropriate help but encourage children to try to do things themselves. This may mean that tasks and chores could take a little more time. Remember that doing things independently helps children build self-confidence and independence. Provide encouragement and patience, and help the other children do the same.

Specific Ways Child Care Providers Can Support Children with Physical Disabilities

Here are some specific ways childcare providers can support the learning of children who have physical disabilities.

Make it easy to move around in play areas.

- Use heavy, stable furniture and equipment that cannot be easily knocked over.
- Remove rugs that can be tripped over, or tape them down.
- Arrange furniture and equipment with a wide aisle so children can move around more freely.
- Provide a safe place for walkers, crutches, wheelchairs, or canes so other children do not trip over them.
- Work with parents to find comfortable ways for a child to sit. A corner with two walls for support, a chair with a seat belt, or a wheelchair with a large tray across the arms are three possibilities that may help children with certain physical disabilities participate more fully in childcare activities.
- Make objects steadier. For example, secure paper, mixing bowls or wood blocks to the table or floor so they remain in place as the child paints, draws, stirs or hammers.

Adapt learning activities.

- Provide tools that children with motor disabilities can use for grasping, holding, transferring and releasing.
- Be sure objects are age appropriate. For example, a bean bag made from dinosaur fabric is much more appropriate for a 5-year-old than a rattle or a baby toy.
- Provide materials of different textures — such as play dough, fabric swatches, ribbon, corrugated cardboard and sandpaper — to stimulate the sense of touch.
- Be sure activity areas are well-lighted. Add lamps if needed.

- Plan activities to encourage all children to move all body parts. Work with parents and specialists to choose special exercises for the child and encourage the whole class to do some of them as part of a large group activity.
- Add tabs to books for turning pages.
- Place tape on crayons and markers to make them easier to grip.
- Secure paint brushes into a glove or provide paint brushes with large knobs on the ends.
- Consider buying scissors that open automatically when squeezed, or scissors that do not require children to use finger holes.
- Provide spray bottles to practice the squeezing motion needed to use scissors.
- Keep items contained. Roll a ball inside a hula hoop placed on the floor. Play with blocks on a cookie sheet or the lid of a cardboard box.

Teach classmates how to help a child with a physical disability.

- Playmates are usually eager to assist children with disabilities but may take over and provide too much help. Applaud and encourage helping behaviors, but also teach children to encourage their classmate to do as much as possible on his own.
- Teach children how to offer help respectfully. Encourage them to ask if the child wants help first, and to take “no” as an answer.
- Encourage children to find creative ways to include a child with a physical disability in their play activities. For example, moving blocks to a table might make it easier for a child in a wheelchair to participate.

Learning and Behavior Disorders Lecture

By Elisabeth Fuller. 2022i

Learning Disabilities

Learning disabilities can be difficult to notice in early education because of the developmental milestones children are working through and the types of mistakes all children make as they learn language. However, there are some key behaviors that may signal a learning disability. For example, if children are late to talk, have difficulty rhyming, singing the alphabet song, remembering the order of events, or following verbal directions, or if they are restless, easily distracted, and have trouble interacting with peers, they may have a learning disability.

There are seven main learning disabilities:

- Dyslexia
- Dysgraphia
- Dyscalculia
- Auditory processing disorder
- Language processing disorder
- Nonverbal learning disabilities
- Visual perceptual/visual motor deficit

For the discussion, you will be choosing one learning disability to research and provide information on.

Behavior Disorders

Behavior refers to how a child conducts him/herself in terms of actions and reactions to environmental situations. In early childhood, there is a wide range of behaviors that are considered normal since children are learning the differences between home and school and how to behave in different environments while also developing and growing. Behaviors like temper tantrums, aggression, defiance, and fussiness are all part of developing these skills and can be caused by tiredness, hunger, and changes in routines. For this reason, behavior disorders are also often diagnosed in elementary school when the limitations of the classroom setting make it difficult for children to self-regulate. However, it is how we deal with challenging behaviors at this age that can help children as they develop and grow.

9 Preschool Behaviors that Could Signal a Learning Disability

Instructions

Gold (2022) provides some guidelines for awareness around learning disabilities in early education - these are usually diagnosed in elementary school years, but signs can be present earlier if you know what to look for. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Sunny Sea Gold. 2022


PHOTO: GETTY

An estimated one in five school-age children has a learning and attention disability, and early signs often show up as developmental delays in the toddler and preschool years.

"However, children develop differently, and there is a whole universe of possibilities for what's causing any one behavior," says Rebecca Parlakian, senior director of programs at Zero to Three, the National Center for Infants, Toddlers, and Families.

A delay in fine motor skills could be a typical blip in development, or it might indicate something more serious. But one thing's certain: The earlier that parents and teachers can identify delays and start early interventions, the better kids will perform socially and academically down the road.

To help determine whether your toddler or preschooler's development is on track, consider the nine questions below.

1. Do They Have a Vocabulary of 200 Words or More?

Most 3-year-olds can rattle off the words for body parts, everyday objects, and basic pronouns such as "you" or "me." They'll also start asking "why?" and begin using plurals. Speech and language problems are often one of the first signs of a learning disability such as an auditory- or language processing disorder in which a child's brain has difficulty interpreting or using sound or language.

Undiagnosed hearing loss—or even chronic ear infections—can also delay speech, says Mark Griffin, Ph.D., a longtime special-education expert who consults for Understood, a nonprofit advocacy group for parents and kids with learning and attention issues. A child's hearing is checked at birth and again at around age 5, but you can ask your pediatrician for an assessment before then if you're concerned.

2. Can They Say How Old They Are?

By 36 months, preschoolers should understand the concept of "how many" and be able to hold up fingers for how old they are. They should be able to "count," in that they can recite several numbers in order (though they often skip some). At age 4, kids can usually count up to 20. A persistent delay in this area might be an early sign of dyscalculia, a learning disability that interferes with understanding numbers and telling time, Dr. Griffin says.

3. Does Your Child Know Their ABCs?

Between 3 and 4 years old, children should be able to recognize ten or more letters when they see them. Some can spot their own first name or even a few words they see frequently. If your child is falling behind most of their peers in this area, it could point to a language-processing disorder or dyslexia, a learning disability that causes difficulty in reading, writing, and spelling.

4. Does Your Child Seem Less Mature Than Other Kids Their Age?

Kids with ADHD could be as much as three years behind other children their age in certain aspects of brain development, according to a study from the National Institutes of Health. "Social and emotional skills are really important when transitioning to kindergarten," says Parlakian. Kids need to be able to cooperate with peers and manage their own frustration

without hitting or throwing tantrums. "Even adults freak out once in a while, but by age 5, a child should be able to regulate her emotions in an age-appropriate way, such as persisting through an obstacle or challenge instead of giving up in frustration the way a younger child might," says Parlakian. If your child isn't quite there yet, it doesn't mean they have ADHD or will develop a learning disability. "Still, you should keep an eye on the situation," says Dr. Griffin.

5. Do They Try to "Read"?

Preschoolers can answer questions about what they see in books and may pretend to read by turning pages and making up stories based on the illustrations. At age 4, most can also recite some of the lines from a favorite book by heart. (Or will catch you when you try to skip over things. Gah!) This means they are learning that pictures help tell the story, and they understand that the symbols (letters) on the page have meaning—an important early literacy skill, Parlakian says.

6. How Are Their Table Manners?

Between ages 3 and 4, most children will be able to hold a fork and a spoon with their fingers instead of in their fists. Similarly, preschoolers should also be able to grip a thick crayon or marker with their fingers. A child who isn't doing these things could be experiencing a delay in fine motor skills—sometimes an early sign of dysgraphia, a learning disability that makes writing difficult.

7. Does Your Child "Ignore" Their Friends When They Call Their Name?

This might hint at an auditory- or visual-processing deficit that hinders your child's ability to understand and use information that they hear or see. These deficits can affect speech, memory, and knowing where objects are in space.

8. Is Your Child a Stair Master?

It should be tough to keep a preschooler out of anywhere. By age 3, they should be easily walking up and down stairs, jumping, and working door handles on their own. Children who don't do this may have gross motor delays.

9. Do They Play "Pretend" with Friends?

Between ages 3 and 4, your child should play with other kids rather than just alongside them and gravitate toward imaginative, pretend play. If they don't, talk to your pediatrician about whether they may have a delay in social skills.

Early Warning Signs of a Learning Disability

Instructions

Rauch (2020) discusses identifying learning disabilities in young children, but also the evaluation process and what can be done to help young children with learning disabilities. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Catherine Ann Rauch. 2020

How can I tell if my child has a learning disability?

During the preschool and kindergarten years, children learn at different rates and with different styles. But if your child has significant trouble with numbers, letters, or speech, he may have a learning disability. Learning disabilities are a category of disorders that stem from how the brain processes information, making it difficult to grasp some concepts.

A child with a learning disability may understand a story perfectly when it is read to him but will struggle to answer questions about it afterward. Another child might easily recite the alphabet from A to Z but be unable to name individual letters when they're pointed out. Still another child may have a hard time putting together puzzles, tying his shoes, or buttoning a sweater.

Children with learning disabilities may have normal or above normal intelligence, but they have trouble expressing their knowledge. Because it is so difficult for children with learning disabilities to master certain tasks, they often experience frustration, anger, low self-esteem, and even depression. Your child may know just what he wants to accomplish – to say or write or do – but getting there isn't a straight path.

"Information going in the eyes and ears is somehow not translated correctly. What comes out is not the correct answer," says Ron Liebman, a child psychiatrist in Wynnewood, Pennsylvania. "We're talking about children with normal IQs."

What are the warning signs of a learning disability in children aged 5 and under?

Learning disabilities are often grouped into three categories: speech or language disorders; problems with reading, writing, or math skills; and a range of other disorders such as problems with coordination, motor skills, or memory.

Sometimes it's clear that a child has one kind of disability, such as dyslexia or dyscalculia – disorders that impair reading and math abilities, respectively. But it's also common for children to have a combination of different disorders.

Attention deficit disorders are not by themselves learning disabilities. But children with learning disabilities frequently have attention problems, as well.

Red flags that could indicate a learning disability in children aged 5 and under include:

- Delayed speech
- Pronunciation problems
- Difficulty learning new words
- Difficulty learning to read
- Trouble learning numbers, the alphabet, days of the week, or colors and shapes
- Poor concentration
- Difficulty following directions
- Poor grasp of a crayon or pen
- Difficulty with buttoning, zipping, and tying

How can I have my child evaluated?

Diagnosing learning disabilities is controversial. Some experts believe they are over diagnosed, a handy catchall for a host of normal differences in learning styles. Diagnosing learning disabilities in preschoolers and very young children is particularly controversial because they learn at such vastly different rates.

Some of the criteria for making a diagnosis of a learning disability may not become apparent until the early grades in grade school. But any developmental delays can and should be evaluated starting in infancy. There are many types of early intervention services that can address delays and children can benefit enormously from working on these skills at an early age, which can help children reach their full potential. If you're worried about your child's competence with reading, writing, numbers, or speech, talk about it with people who are familiar with your child, such as your child's teacher.

Teachers are usually adept at spotting the early warning signs of a learning disability. If your child's teacher hasn't already raised the issue with you, don't hesitate to bring up your concerns. Talk to your child's doctor, too.

Sometimes what you worry may be a learning disability is just a temporary setback that your child will outgrow. But it's best not to wait and see. You'll be doing your child a favor if you trust your instincts and talk to her teacher or doctor about getting an evaluation if her development seems off to you.

Your child will need a formal evaluation for learning disabilities – usually done by a child psychologist, neuropsychologist, neurodevelopmental pediatrician, or psychiatrist – to know for sure whether she has a problem. The evaluation is done in an office setting and takes a couple of hours. Your child will be asked to do various tasks using toys and educational materials.

Your public school district should be able to help arrange an evaluation. By law, every school district must have a procedure for identifying, assessing, and planning an educational program for kids with any kind of disability, including learning disabilities.

What can be done to help a child with learning disabilities?

Learning disabilities are permanent and don't go away. But much can be done to help your child compensate for the disability and learn to work around the problem. For instance, the teacher can present materials in different ways, and your child can practice skills over and over again in a setting that is supportive and patient. Children with learning disabilities can and do learn.

As a parent, one of the most important things you can do is support your child and assist with positive learning experiences. The goal is to focus on your child's strengths. If he struggles with the alphabet but loves animals, encourage that interest and help him become an animal expert.

Give your child lots of self-esteem boosts by encouraging his skills and passions. "Plan activities that you know your child can do and be successful at," says Nicki Arnold, a psychologist and mother of a son with learning disabilities. Arnold nurtured her son's love for skiing when he was just 5 and wasn't doing well academically.

Don't try to be an expert on treating learning disabilities yourself. Your job is to provide encouragement, love, and patience and to seek out experts who have the skills to help your child learn. If your child has been diagnosed, he should be eligible for special services.

State and federal disability laws require many children with learning disabilities to receive free services. There are special private schools for children with learning disabilities, but these can be expensive. Consult with your child's teacher or local organizations serving children with disabilities.

Psychological counseling can also help. Children with learning disabilities often feel like failures, leading to low self-esteem. They are often frustrated, and their frustration can turn into anger. "The emotional or psychological issues are, in my mind, more important than learning that two plus two equals four," Liebman says.

Parents need to learn how to handle their child's emotional outbursts. Although conventional wisdom says that you shouldn't encourage a child who's a tantrum or crying fit, this kind of emotional release can be beneficial for kids with learning disabilities. If you stay close to your

child during these times and tell him that you love him and you know that things are hard for him, you show her that he doesn't have to struggle alone – you'll always be there to help him.

Remember to take care of yourself, too. Being the parent of a child with learning problems is stressful. Many disability organizations also have support groups and counseling for parents.

Behavioural and Emotional Disorders in Childhood: A Brief Overview for Paediatricians

Instructions

While this resource is a bit longer than I usually like to include, it has a ton of useful information about behavioral and emotional disorders. It is comprehensive information from definitions to strategies, including prescriptions and behavioral strategies. It is definitely worth at least a quick skim to read what interests you most. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Michael O. Ogundele. 2018

Introduction

Mental health disorders (MHD) are very common in childhood, and they include emotional-obsessive-compulsive disorder (OCD), anxiety, depression, disruptive (oppositional defiance disorder (ODD), conduct disorder (CD), attention deficit hyperactive disorder (ADHD) or developmental (speech/language delay, intellectual disability) disorders or pervasive (autistic spectrum) disorders. Emotional and behavioural problems (EBP) or disorders (EBD) can also be classified as either “internalizing” (emotional disorders such as depression and anxiety) or “externalizing” (disruptive behaviours such as ADHD and CD). The terminologies of “problems” and “disorders” are interchangeably used throughout this article.

While low-intensity naughty, defiant and impulsive behaviour from time to time, losing one’s temper, destruction of property, and deceitfulness/stealing in the preschool children are regarded as normal, extremely difficult and challenging behaviours outside the norm for the age and level of development, such as unpredictable, prolonged, and/or destructive tantrums and severe outbursts of temper loss are recognized as behaviour disorders. Community studies have identified that more than 80% of pre-schoolers have mild tantrums sometimes but a smaller proportion, less than 10% will have daily tantrums, regarded as normative misbehaviours at this age. Challenging behaviours and emotional difficulties are more likely to be recognized as “problems” rather than “disorders” during the first 2 years of life.

Emotional problems, such as anxiety, depression and post-traumatic stress disorder (PTSD) tend to occur in later childhood. They are often difficult to be recognised early by the parents or other carers as many children have not developed appropriate vocabulary and comprehension to express their emotions intelligibly. Many clinicians and carers also find it difficult to distinguish between developmentally normal emotions (*e.g.*, fears, crying) from the severe and prolonged emotional distresses that should be regarded as disorders. Emotional problems including disordered eating behaviour and low self-image are often associated with chronic medical disorders such as atopic dermatitis, obesity, diabetes and asthma, which lead to poor quality of life.

Identification and management of mental health problems in primary care settings such as routine Paediatric clinic or Family Medicine/General Practitioner surgery are cost-effective because of their several desirable characteristics that make it acceptable to children and young people (CYP) (*e.g.*, no stigma, in local setting, and familiar providers). Several models to improve the delivery of mental health services in the Paediatric/Primary care settings have been recommended and evaluated recently, including coordination with external specialists, joint consultations, improved Mental Health training and more integrated on-site intervention with specialist collaboration.

A review of relevant published literature was conducted, including published meta-analyses and national guidelines. We searched for articles indexed by Ovid, PubMed, PubMed Medical Central, CINAHL, the Cochrane Database of Systematic reviews and other online sources. The searches were conducted using a combination of search expressions including “childhood”, “behaviour”, “disorders” or “problems”.

Clinical Presentations of Childhood Behavioural and Emotional Disorders

Various definitions for a wide range of childhood behavioural disorders are being used. The DSM-5 offers the commonest universally accepted standard criteria for the classification of mental and behaviour disorders. The ICD-10 is the alternative classification standard.

Challenging behaviours

Any abnormal pattern of behaviour which is above the expected norm for age and level of development can be described as “challenging behaviour”. It has been defined as: “Culturally abnormal behaviour (s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy or behaviour which is likely to seriously limit or deny access to and use of ordinary community facilities”. They can include self-injury, physical or verbal aggression, non-compliance, disruption of the environment, inappropriate vocalizations, and various stereotypies. These behaviours can impede learning, restrict access to normal activities and social opportunities, and require a considerable amount of both manpower and financial resources to manage effectively.

Many instances of challenging behaviour can be interpreted as ineffective coping strategies for a young person, with or without learning disability (LD) or impaired social and communication skills, trying to control what is going on around them. Young people with various disabilities,

including LD, Autism, and other acquired neuro-behavioural disorders such as brain damage and post-infectious phenomena, may also use challenging behaviour for specific purposes, for example, for sensory stimulation, gaining attention of carers, avoiding demands or to express their limited communication skills. People who have a diverse range of neurodevelopmental disorders are more likely to develop challenging behaviours.

Some environmental factors have been identified which are likely to increase the risk of challenging behaviour, including places offering limited opportunities for making choices, social interaction or meaningful occupation. Other adverse environments are characterized by limited sensory input or excessive noise, unresponsive or unpredictable carers, predisposition to neglect and abuse, and where physical health needs and pain are not promptly identified. For example, the rates of challenging behaviour in teenagers and people in their early 20s is 30%-40% in hospital settings, compared to 5% to 15% among children attending schools for those with severe LD.

Aggression is a common, yet complex, challenging behaviour, and a frequent indication for referral to child and adolescent Psychiatrists. It commonly begins in childhood, with more than 58% of preschool children demonstrating some aggressive behaviour. Aggression has been linked to several risk factors, including individual temperaments; the effects of disturbed family dynamics; poor parenting practices; exposure to violence and the influence of attachment disorders. No single factor is sufficient to explain the development of aggressive behaviour. Aggression is commonly diagnosed in association with other mental health problems including ADHD, CD, ODD, depression, head injury, mental retardation, autism, bipolar disorder, PTSD, or dyslexia.

Disruptive behaviour problems

Disruptive behaviour problems (DBP) include attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD) and conduct disorder (CD). They constitute the commonest EBPs among CYP. Recent evidence suggests that DBPs should be regarded as a multidimensional phenotype rather than comprising distinct subgroups.

ADHD is the commonest neuro-behavioural disorder in children and adolescents, with prevalence ranging between 5% and 12% in the developed countries. ADHD is characterized by levels of hyperactivity, impulsivity and inattention that are disproportionately excessive for the child's age and development. The ICD-10 does not use the term "ADHD" but "hyperkinetic disorder", which is equivalent to severe ADHD. DSM-5 distinguishes between three subtypes of the disorder: predominantly hyperactive/impulsive, predominantly inattentive and combined types (Table 1).

Table 1

Subtypes	**Predominantly inattentive (ADD)**	**Predominantly hyperactivity/ impulsivity**	**Combined ADHD**

Criteria	6 of 9 inattentive symptoms	6 of 9 hyperactivity/ impulsivity symptoms	Both criteria for (1) and (2)
Details	Fails to pay close attention to details or makes careless mistakes	Squirms and fidgets	
	Has difficulty sustaining attention	Can't stay seated	
	Does not appear to listen	Runs/climbs excessively	
	Struggles to follow through on instructions	Can't play/work quietly	
	Has difficulty with organization	"On the go"/"driven by a motor"	
	Avoids or dislikes tasks requiring a lot of thinking	Blurts out answers	
	Loses things	Is unable to wait for his turn	
	Is easily distracted	Intrudes/interrupts others	
		Talks excessively	
Other criteria	Onset before age of 12, lasting more than 6 months, symptoms pervasive in 2 or more settings, causing significant impairment of daily functioning on development		

ADHD: Attention deficit hyperactivity disorder.

CD refers to severe behaviour problems (Table 2), characterized by repetitive and persistent manifestations of serious aggressive or non-aggressive behaviours against people, animals or property such as being defiant, belligerent, destructive, threatening, physically cruel, deceitful, disobedient or dishonest, excessive fighting or bullying, fire-setting, stealing, repeated lying, intentional injury, forced sexual activity and frequent school truancy. Children with CD often have trouble understanding how other people think, sometimes described as being callous-unemotional. They may falsely misinterpret the intentions of other people as being mean. They may have immature language skills, lack the appropriate social skills to establish and maintain friendships, which aggravates their feelings of sadness, frustration and anger.

Table 2

Oppositional defiant disorder	**Conduct disorder**

A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 mo as evidenced by at least four out of 8 symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling

Angry/irritable mood: (1) Often loses temper; (2) Is often touchy or easily annoyed; (3) Is often angry and resentful

Argumentative/defiant behavior: (4) Often argues with authority figures or, for children and adolescents, with adults; (5) Often actively defies or refuses to comply with requests from authority figures or with rules; (6) Often deliberately annoys others; (7) Often blames others for his or her mistakes or misbehavior

A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of at least three of the following 15 criteria in the past 12 mo from any of the categories below, with at least one criterion present in the past 6 mo

Aggression to people and animals: (1) Often bullies, threatens, or intimidates others; (2) Often initiates physical fights; (3) Has used a weapon that can cause serious physical harm to others (*e.g.*, a bat, brick, broken bottle, knife, gun); (4) Has been physically cruel to people; (5) Has been physically cruel to animals; (6) Has stolen while confronting a victim (*e.g.*, mugging, purse snatching, extortion, armed robbery); (7) Has forced someone into sexual activity

Destruction of property: (8) Has deliberately engaged in fire setting with the intention of causing serious damage; (9) Has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft: (10) Has broken into someone else's house, building, or car; (11) Often lies to obtain goods or favors or to avoid obligations (*i.e.*, "cons" others); (12) Has stolen items of nontrivial value without confronting a victim (*e.g.*, shoplifting, but without breaking and entering; forgery)

Vindictiveness: (8) Has been spiteful or vindictive at least twice within the past 6 months

Serious violations of rules: (13) Often stays out at night despite parental prohibitions, beginning before age 13 yr; (14) Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period; (15) Is often truant from school, beginning before age 13 yr.

Note: The persistence and frequency of these behaviors should be used to distinguish a behavior that is within normal limits from a behavior that is symptomatic, and the behavior should occur at least once per week for at least 6 mo

The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

The disturbance in behavior is associated with distress in the individual or others in his or her immediate social context (*e.g.*, family, peer group, work colleagues), or it impacts negatively on social, educational, occupational, or other important areas of functioning.

If the individual is age 18 yr or older, criteria are not met for antisocial personality disorder.

Specify whether: Childhood-onset type (prior to age 10 yr); Adolescent-onset type or Unspecified onset

Specify if: With limited prosocial emotions: Lack of remorse or guilt; Callous - lack of empathy; Unconcerned about performance or Shallow or deficient affect.

Specify current severity: Mild; Moderate or Severe

The behaviors do not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder. Also, the criteria are not met for disruptive mood dysregulation disorder

ICD-10

It also requires the presence of three symptoms from the list of 15 (above), and duration of at least 6 mo. There are four divisions of conduct disorder: Socialised conduct disorder, unsocialised conduct disorder, conduct disorders confined to the family context and oppositional defiant disorder.

Specify current severity: Mild; moderate or severe based on number of settings with symptoms shown.

CD is the commonest reason for CYP referral for psychological and psychiatric treatment. Roughly 50% of all CYP with a MHD have a CD. About 30%-75% of children with CD also have ADHD and 50% of them will also meet criteria for at least one other disorder including Mood, Anxiety, PTSD, Substance abuse, ADHD, learning problems, or thought disorders. Majority of boys have an onset of CD before the age of 10 years, while girls tend to present mainly between 14 and 16 years of age. Most CYP with CD grow out of this disorder, but a minority become more dissocial or aggressive and develop antisocial personality disorder as adults.

ODD is considered to be the mildest and commonest of the DBPs, with prevalence estimates of 6%-9% for preschoolers and boys outnumbering girls by at least two to one. CYP with ODD are typically openly hostile, negativistic, defiant, uncooperative, and irritable. They lose their tempers easily and are mean and spiteful towards others (Table 2). They are mostly defiant towards authority figures, but they may also be hostile to their siblings or peers. This pattern of adversarial behaviour significantly negatively impacts on their lives at home, school, and wider society, and seriously impairs all their relationships.

Emotional problems

Emotional problems in later childhood include panic disorder, generalized anxiety disorder (GAD), separation anxiety, social phobia, specific phobias, OCD and depression. Mild to moderate anxiety is a normal emotional response to many stressful life situations. Anxiety is regarded as a disorder when it is disproportionately excessive in severity in comparison to the gravity of the triggering circumstances, leading to abnormal disruption of daily routines. Panic disorder is characterized by panic attacks untriggered by external stimuli. GAD is characterized by generalized worry across multiple life domains. Separation anxiety disorder is characterized by fear related to actual or anticipated separation from a caregiver. Social anxiety disorder (also called social phobia) is characterized by fear of social situations where peers may negatively evaluate the person.

Common manifestations of anxiety disorders include physical symptoms such as increased heart rate, shortness of breath, sweating, trembling, shaking, chest pain, abdominal discomfort and nausea. Other symptoms include worries about things before they happen, constant concerns about family, school, friends, or activities, repetitive, unwanted thoughts (obsessions) or actions (compulsions), fears of embarrassment or making mistakes, low self-esteem and lack of self-confidence.

Depression often occurs in children under stress, experiencing loss, or having attentional, learning, conduct or anxiety disorders and other chronic physical ailments. It also tends to run in families. Symptoms of depression are diverse and protean, often mimicking other physical and neurodevelopmental problems, including low mood, frequent sadness, tearfulness, crying, decreased interest or pleasure in almost all activities; or inability to enjoy previously favourite

activities, hopelessness, persistent boredom; low energy, social isolation, poor communication, low self-esteem and guilt, feelings of worthlessness, extreme sensitivity to rejection or failure, increased irritability, agitation, anger, or hostility, difficulty with relationships, frequent complaints of physical illnesses such as headaches and stomach aches, frequent absences from school or poor performance in school, poor concentration, a major change in eating and/or sleeping patterns, weight loss or gain when not dieting, talk of or efforts to run away from home, thoughts or expressions of suicide or self-destructive behaviour.

Disruptive mood dysregulation disorder (DMDD) is a childhood disorder characterized by a pervasively irritable or angry mood recently added to DSM-5. The symptoms include frequent episodes of severe temper tantrums or aggression (more than three episodes a week) in combination with persistently negative mood between episodes, lasting for more than 12 months in multiple settings, beginning after 6 years of age but before the child is 10 years old.

Autistic spectrum and pervasive development disorder

The definition of Autism has evolved over the years and has been broadened over time. DSM-IV-TR and the ICD-10 defined the diagnostic category of pervasive developmental disorders (PDD) as the umbrella terminology used for a group of five disorders characterized by pervasive “qualitative abnormalities in reciprocal social interactions and in patterns of communication, and by a restricted, stereotyped, repetitive repertoire of interests and activities” affecting “the individual’s functioning in all situations”. These included autism, Asperger syndrome, childhood disintegrative disorder (CDD), pervasive developmental disorder not otherwise specified (PDD-NOS) and Rett syndrome.

Autism and Asperger Syndrome are the most widely recognised and clinically diagnosed among this group of disorders. CDD is a term used to describe children who have had a period of normal development for the first 2-3 years before a relatively acute onset of regression and emergence of autistic symptoms. PDD-NOS was used, particularly in the United States, to describe individuals who have autistic symptoms, but do not meet the full criteria for Autism or Asperger’s Syndrome, denote a milder version of Autism, or to describe atypical autism symptoms emerging after 30 months of age, and autistic individuals with other co-morbid disorders.

The category of PDD has been removed from DSM-5 and replaced with autism spectrum disorders (ASD). ASD (Table 3) is diagnosed primarily from clinical judgment usually by a multidisciplinary team, with minimal support from diagnostic instruments. Most individuals who received diagnosis based on the DSM-IV should still maintain their diagnosis under DSM-5, with some studies confirming that 91% to 100% of children with PDD diagnoses from the DSM-IV retained their diagnosis under the ASD category using the new DSM-5, while a systematic review has found a slight decrease in the rate of ASD with DSM-5.

Table 3

DSM-5 criteria for autism spectrum disorders

- Persistent deficits in social communication and social interaction across multiple contexts, as manifested by 3 out 3 of the following, currently or by history.
- Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
- Deficits in nonverbal communicative behaviours used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
- Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.
- Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two out of 4 of the following, currently or by history.
- Stereotyped or repetitive motor movements, use of objects, or speech (*e.g.*, simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
- Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (*e.g.*, extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).
- Highly restricted, fixated interests that are abnormal in intensity or focus (*e.g.*, strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).
- Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (*e.g.*, apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).
- Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities or may be masked by learned strategies in later life).
- Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities or may be masked by learned strategies in later life).
- Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
- Specify if
    - With or without accompanying intellectual impairment With or without accompanying language impairment.
    - Associated with a known medical or genetic condition or environmental factor.
    - Specify current severity based on social communication impairments and restricted repetitive patterns of behavior.

There are many intervention approaches and strategies, used alone or in combination, for supporting individuals with ASD. These interventions need to be individualized and closely tailored to the level of social and linguistic abilities, cultural background, family resources, learning style and degree of communication skills.

Various communication enhancement strategies have been designed to manage ASD, including augmentative and alternative communication (AAC), Facilitated Communication, computer-based instruction and video-based instruction (Table 4). Several behavioural and psychological interventions (Table 5) have also been used successfully in managing ASD children, including applied behaviour analysis (ABA) and functional communication training (FCT).

Table 4

Method	Description
Augmentative and alternative communication	Supplements/replaces natural speech and/or writing with aided [*e.g.*, Picture Exchange Communication System, line drawings, Blissymbols, speech generating devices, and tangible objects] and/or unaided (*e.g.*, manual signs, gestures, and finger spelling) symbols
	Effective in decreasing maladaptive or challenging behaviour such as aggression, self-injury and tantrums, promotes cognitive development and improves social communication
Activity schedules/visual supports	Using photographs, drawings, or written words that act as cues or prompts to help individuals complete a sequence of tasks/activities or behave appropriately in various settings
	Scripts are often used to promote social interaction, initiate or sustain interaction
Computer-/video-based instruction	Use of computer technology or video recordings for teaching language skills, social skills, social understanding, and social problem solving

Table 5

Method	Description
ABA	Uses principles of learning theory to bring about meaningful and positive change in behaviour, to help individuals build a variety of skills (*e.g.*, communication, social skills, self-control, and self-monitoring) and help generalize these skills to other situations

Discrete trial training	A one-to-one instructional approach based on ABA to teach skills in small, incremental steps in a systematic, controlled fashion, documenting stepwise clearly identified antecedent and consequence (*e.g.*, reinforcement in the form of praise or tangible rewards) for desired behaviours
Functional communication training	Combines ABA procedures with communicative functions of maladaptive behaviour to teach alternative responses and eliminate problem behaviours
Pivotal response treatment	A play-based, child-initiated behavioural treatment, designed to teach language, decrease disruptive behaviours, and increase social, communication and academic skills, building on a child's initiative and interests
Positive behaviour support	Uses ABA principles with person-centred values to foster skills that replace challenging behaviours with positive reinforcement of appropriate words and actions. PBS can be used to support children and adults with autism and problem behaviours
Self-management	Uses interventions to help individuals learn to independently regulate, monitor and record their behaviours in a variety of contexts, and reward themselves for using appropriate behaviours. It's been found effective for ADHD and ASD children
Time delay	It gradually decreases the use of prompts during instruction over time. It can be used with individuals regardless of cognitive level or expressive communication abilities
Incidental teaching	Utilizes naturally occurring teaching opportunities to reinforce desirable communication behaviour
Anger management	Various strategies can be used to teach children how to recognise the signs of their growing frustration and learn a range of coping skills designed to defuse their anger and aggressive behaviour, teach them alternative ways to express anger, including relaxation techniques and stress management skills

ABA: Applied behaviour analysis; ADHD: Attention deficit hyperactivity disorder; ASD: Autistic spectrum disorder.

Social (pragmatic) communication disorder

Social (pragmatic) communication disorder (SCD) is a new diagnosis included under Communication Disorders in the Neurodevelopmental Disorders section of the DSM-5. It is characterized by persistent difficulties with using verbal and nonverbal communication for social purposes, which can interfere with interpersonal relationships, academic achievement and occupational performance, in the absence of restricted and repetitive interests and behaviours (Table6) . Some authors consider that CYP with SCD present with similar but less severe

restricted and repetitive interests and behaviours (RRIBs) characteristic of children on the autistic spectrum. SCD is thought to occur more frequently in family members of individuals with autism.

Table 6

DSM-5 criteria for social (pragmatic) communication disorder

- Persistent difficulties in the social use of verbal and nonverbal communication as manifested by all of the following.
- Deficits in using communication for social purposes, such as greeting and sharing information, in a manner that is appropriate for social context.
- Impairment in the ability to change communication to match context or the needs of the listener, such as speaking differently in a classroom than on a playground, talking differently to a child than to an adult, and avoiding use of overly formal language.
- Difficulties following rules for conversation and storytelling, such as taking turns in conversation, rephrasing when misunderstood, and knowing how to use verbal and nonverbal signals to regulate interaction.
- Difficulties understanding what is not explicitly stated (*e.g.*, making inferences) and nonliteral or ambiguous meaning of language (*e.g.*, idioms, humor, metaphors, multiple meanings that depend on the context for interpretation).
- The deficits result in functional limitations in effective communication, social participation, social relationships, academic achievement, or occupational performance, individually or in combination.
- The onset of the symptoms is in the early developmental period (but deficits may not become fully manifest until social communication demands exceed limited capacities.
- The symptoms are not attributable to another medical or neurological condition or to low abilities in the domains of word structure and grammar; and are not better explained by autism spectrum disorder; intellectual disability (intellectual developmental disorder), global developmental delay, or another mental disorder.

The term “pragmatic” has been used previously to describe the communication skills that are needed in normal social intercourse and the rules that govern routine interpersonal interactions, including ability to pay at least some attention to the other person in a conversation, take turns, not interrupting the other speaker unless there is a very good reason, match language and volume to the situation and the listener, etc. Social and pragmatic deficit are known to also occur in diverse clinical populations, including ADHD, William’s syndrome, CD, closed head injury and spina bifida/hydrocephalus.

Treatment modalities that have been used for supporting children with SCD are similar to those that have been used for several years in children with ASD (Tables 4 and 5). The first randomized controlled trial of social communication interventions designed primarily for children with SCD was reported in 2012. The Social Communication Intervention Project () targets development in social understanding and interaction, verbal and non-verbal pragmatic skills and language processing among children with SCD.

Pathological demand avoidance or Newson's syndrome

Pathological demand avoidance (PDA) or Newson's Syndrome is increasingly being accepted as part of the autism spectrum. PDA was first used in 2003 for describing some CYP with autistic symptoms who showed some challenging behaviours. It is characterized by exceptional levels of demand avoidance requested by others, due to high anxiety levels when the individuals feel that they are losing control. Avoidance strategies can range from simple refusal, distraction, giving excuses, delaying, arguing, suggesting alternatives and withdrawing into fantasy, to becoming physically incapacitated (with an explanation such as "my legs don't work") or selectively mute in many situations. If they feel threatened to comply, they may become verbally or physically aggressive, best described as a "panic attack", apparently intended to shock. They tend to resort to "socially manipulative" behaviours. The outrageous acts and lack of concern for their behaviour appears to draw parallels with conduct problems (CP) and callous-unemotional traits (CUT), but reward-based techniques, effective with CP and CUT, seem not to work in people with PDA. PDA is currently neither part of the DSM-5 nor the ICD-10.

Though demand avoidance is a common characteristic of CYP with ASD, it becomes pathological when the levels are disproportionately excessive, and normal daily activities and relationships are negatively impaired. Unlike typically autistic children, people with PDA tend to have much better social communication and interaction skills and are consequently able to use these abilities to their advantage. They often have highly developed social mimicry and role play, sometimes becoming different characters or personas. The people with PDA appear to retain a keen awareness of how to "push people's buttons", suggesting a level of social insight when compared to CYP with Autism. On the other hand, children with PDA exhibit higher levels of emotional symptoms compared to those with ASD or CD. They also often experience excessive mood swings and impulsivity. While the prevalence of ASD in boys is more than four times higher compared to that of girls, the risk of developing PDA appears to be the same for both boys and girls.

O'Nions et al have recently reported on the development and preliminary validation of the "Extreme Demand Avoidance Questionnaire" (EDA-Q), designed to quantify PDA traits based on parent-reported information, with good sensitivity (0.80) and specificity (0.85). EDA-Q is available online (https://).

Prevalence of Behavioural and Emotional Disorders in Childhood

Accurate estimation of various childhood EBPs is difficult due to the problems of research methodologies relying on subjective assessments and varying definitions used. According to most studies, between 10% and 20% of CYP are affected annually by MHDs, and the rates are very similar across different racial and ethnic groups after controlling for income, resident status, education, and neighbourhood support. However, poverty and low socioeconomic status are risk factors that appear to increase the rate of MHDs across populations. A 2001 WHO report indicated the 6-mo prevalence rate for any MHD in CYP, up to age 17 years, to be 20.9%, with disruptive behaviour disorders (DBD) at 10.3%, second only to anxiety disorders at 13%. About

5% of CYP in the general population suffer from Depression at any given point in time, which is more prevalent among girls (54%).

A previous British Child and Adolescent Mental Health (CAMH) survey carried out by the office of National Statistics (ONS) in 1999 and 2004, comprising 7977 interviews from parents, children and teachers, found the prevalence of MHD among CYP (aged 5-16 years) to be 6% for conduct problems, 4% for emotional problems (Depression or Anxiety) and 1.5% for Hyperkinetic disorders. A similar survey in the United States between 2005 and 2011, the National survey of children's health (NSCH) involving 78042 households, indicated that 4.6% of CYP aged 3-17 years had a history DBD, with prevalence twice as high among boys as among girls (6.2% *vs* 3.0%), Anxiety (4.7%), Depression (3.9%), and ASD (1.1%). Reported prevalence rates for DMDD range from 0.8% to 3.3% with the highest rate in preschool children.

Aetiology and Risk Factors for Children's Behavioural and Emotional Disorders

The exact causes of various childhood EBPs are unknown. Several studies have identified various combinations of genetic predisposition and adverse environmental factors that increase the risk of developing any of these disorders. These include perinatal, maternal, family, parenting, socio-economic and personal risk factors. Table 7 summarizes the evidence for various risk factors associated with development of childhood EBPs.

Table 7

Summary of common risk factors for development of childhood emotional and behavioural disorder**Domain****Characteristic examples**Maternal psychopathology (mental health status)Low maternal education, one or both parents with depression, antisocial behaviour, smoking, psychological distress, major depression or alcohol problems, an antisocial personality, substance misuse or criminal activities, teenage parental age, marital conflict, disruption or violence, previous abuse as a child and single (unmarried status)Adverse perinatal factorsMaternal gestational moderate alcohol drinking, smoking and drug use, early labour onset, difficult pregnancies, premature birth, low birth weight, and infant breathing problems at birthPoor child-parent relationshipsPoor parental supervision, erratic harsh discipline, parental disharmony, rejection of the child, and low parental involvement in the child's activities, lack of parental limit settingAdverse family lifeDysfunctional families where domestic violence, poor parenting skills or substance abuse are a problem, lead to compromised psychological parental functioning, increased parental conflict, greater harsh, physical, and inconsistent discipline, less responsiveness to children's needs, and less supportive and involved parentingHousehold tobacco exposureSeveral studies have shown a strong exposure–response association between second-hand smoke exposure and poor childhood mental healthPoverty and adverse socio-economic environmentPersonal and community poverty signs including homelessness, low socio-economic status, overcrowding and social isolation, and exposure to toxic air, lead, and/or pesticides or early childhood malnutrition often lead to poor mental health development Chronic stressors associated with poverty such as single-parenthood, life stress, financial worries, and ever-present challenges cumulatively compromise parental psychological functioning, leading to higher levels of distress, anxiety, anger, depressive symptoms and substance use in disadvantaged parents.Chronic stressors in children also lead to abnormal

behaviour pattern of ‘reactive responding’ characterized by chronic vigilance, emotional reacting and sense of powerlessnessEarly age of onsetEarly starters are likely to experience more persistent and chronic trajectory of antisocial behavioursPhysically aggressive behaviour rarely starts after age 5Child’s temperamentChildren with difficult to manage temperaments or show aggressive behaviour from an early age are more likely to develop disruptive behavioural disorders later in lifeChronic irritability, temperament and anxiety symptoms before the age of 3 yr are predictive of later childhood anxiety, depression, oppositional defiant disorder and functional impairmentDevelopmental delay and Intellectual disabilitiesUp to 70% of preschool children with DBD are more than 4 times at risk of developmental delay in at least one domain than the general populationChildren with intellectual disabilities are twice as likely to have behavioural disorders as normally developing childrenRate of challenging behaviour is 5% to 15% in schools for children with severe learning disabilities but is negligible in normal schoolsChild’s genderBoys are much more likely than girls to suffer from several DBD while depression tends to predominantly affect more girls than boysUnlike the male dominance in childhood ADHD and ASD, PDA tends to affect boys and girls equally

ADHD: Attention deficit hyperactivity disorder; ASD: Autistic spectrum disorder; DBD: Disruptive behaviour disorder; PDA: Pathological demand avoidance.

There is ample evidence supporting the genetic inheritability of many EBDs in CYP from their parents. From a prospective study of 209 parents along with their 331 biological offsprings, moderate inheritability ($r = 0.23$, $P < 0.001$) between parental and offspring CD was found. Anxiety seems to be transmissible from mothers to their preschool children, through both genetic factors and also through behaviour modelling and an anxious style of parenting.

A developmental taxonomy theory has been proposed by Patterson et al to help understand the mechanisms underlying early onset and course of CPs. They described the vicious cycle of non-contingent parental responses to both prosocial and antisocial child behaviour leading to the inadvertent reinforcement of child behaviour problems. Parents’ engagement in “coercive cycles” lead to children learning the functional value of their aversive behaviours (*e.g.*, physical aggression) for escape and avoidance from unwanted interactions, ultimately leading to the use of heightened aversive behaviours from both the child and parents to obtain social goals. This adverse child behavioural training combined with social rejection often lead to deviant peer affiliation and delinquency in adolescence.

Neurobiology of Childhood Behavioural and Emotional Disorders

Conflicting findings have been reported in the brain structural variations among CYP with EBPs using magnetic resonance imaging (MRI) studies. The most consistently reported structural abnormalities associated with the DBD include reduced grey matter volume (GMV) in the amygdala, frontal cortex, temporal lobes, and the anterior insula, which is involved in part of a network related to empathic concern for others. Reduced GMV along the superior temporal sulcus has also been found, particularly in girls. A decreased overall mean cortical thickness, thinning of the cingulate and prefrontal cortices; and decreased grey matter density in different brain regions have been reported.

Subtle neurobiological changes in different parts of the brain of CYP with EBPs have been reported from many research studies of functional scans. Peculiar brain changes have been found in the hypothalamus, inferior and superior parietal lobes, right amygdala and anterior insula. Functional MRI studies have demonstrated less activation in the temporal cortex in violent adult offenders and in antisocial and psychopathic individuals compared to non-aggressive offenders.

Reduced basal Hypothalamic-Pituitary-Adrenal (HPA) axis activity has been reported in relation to childhood DBDs and exposure to abuse and neglect. It has been hypothesized that high levels of prenatal testosterone exposure appear to be part of the complex aetiology of EBDs, providing possible explanation for the higher prevalence in males for DBDs, by increasing susceptibility to toxic perinatal environments such as exposure to maternal nicotine and alcohol in pregnancy.

Complications of Childhood Behavioural and Emotional Disorders

EBDs in childhood, if left untreated, may have negative short-term and long-term effects on an individual's personal, educational, family and later professional life. CD has been linked to failure to complete schooling, attaining poor school achievement, poor interpersonal relationships, particularly family breakup and divorce, and experience of long-term unemployment. DBPs in parents have been linked to the abuse of their offspring, thereby increasing their risk of developing CD. Children presenting with hyperactivity-inattention behaviours are more likely to have a more favourable educational outcome compared with those with aggression or oppositional behaviours.

A high prevalence of sleep disturbances is associated with various childhood EBPs. Sleep problems in early childhood is associated with increased prevalence of later anxiety disorders and ODD.

Several studies have confirmed a strong relationship between early childhood EBPs and poor future long-term physical and mental health outcomes. Chronic irritability in preschool children, CD and ODD in older children each may be predictive of any current and lifetime Anxiety, Depression and DBDs in later childhood, Mania, Schizophrenia, OCD, major depressive disorder and panic disorder. Individuals on the adolescent-onset CP path often consume more tobacco and illegal drugs and engage more often in risky sexual behaviour, self-harm, and have increased risk of PTSD, than individuals without childhood conduct problems. They also frequently experience parenting difficulties, including over-reactivity, lax and inconsistent discipline, child physical punishment and lower levels of parental warmth and sensitivity. Approximately 40%-50% of CYP with CD are at the risk of developing antisocial personality disorder in adulthood. Other potential complications include adverse mental and physical health outcomes, social justice system involvement including incarceration, substance use and abuse, alcoholism, homelessness, poverty and domestic abuse.

An analysis of several Scandinavian studies up to the 1980s has shown higher rates of violent death, estimated to be almost five times higher than expected among young people with

previous MHD, with common associated predictive factors including behavioural problems, school problems, and co-morbid alcohol or drug abuse and criminality.

Assessment and Diagnosis of Childhood Behavioural and Emotional Disorders

Assessment through detailed history taking as well as observation of a child's behaviour are indispensable sources of information required for clinical diagnosis of EBPs. This should include general medical, developmental, family, social, educational and emotional history. Physical and neurological examination should include assessment of vision, hearing, dysmorphic features, neuro-cutaneous stigmata, motor skills and cognitive assessment. Condition-specific and generic observer feedback on screening rating scales and questionnaires can be used to complement direct clinical observations.

There is no single gold-standard diagnostic tool available for the diagnosis of EBDs, which largely depends on the clinical skills of an integrated collaboration of multi-professional experts. Diagnosis relies on interpretation of subjective multi-source feedback from parents or carers, teachers, peers, professional or other observers provided through a number of psychometric questionnaires or screening tools. Significant discrepancies between various respondents are quite common and clinical diagnosis cannot rely on the psychometric tools alone. There is evidence from the literature suggesting that parents have a tendency to over-report symptoms of ODD and CD in children compared to the teachers.

There are several screening tools that are used for assessing the risk of MHD among CYP. The tools help to identify which individuals would require more in-depth clinical interventions. Supplement material shows a list of common Mental Health screening and assessment tools, summarizing their psychometric testing properties, cultural considerations and costs. The commonest behaviour screening tools include the Behavioral and Emotional Screening System (BESS; ages 3-18 years), the Behavior Assessment System for Children-2nd edition, Pediatric Symptom Checklist (PSC), the Ages and Stages Questionnaire-Social Emotional (ASQ-SE, Ages 0 to 5 years) and the Achenbach System of Empirically Based Assessment (ASEBA), for children aged 1.5 years through adulthood.

Management of Behavioral and Emotional Disorders in Children

Identification of appropriate treatment strategies depend on careful assessment of the prevailing symptoms, the family and caregiver's influences, wider socio-economic environment, the child's developmental level and physical health. It requires multi-level and multi-disciplinarian approaches that include professionals such as Psychologists, Psychiatrists, Behavioural Analysts, Nurses, Social care staff, Speech and language Therapists, Educational staff, Occupational Therapists, Physiotherapists, Paediatricians and Pharmacists. Use of pharmacotherapy is usually considered only in combination with psychological and other environmental interventions.

Holistic management strategies will include various combinations of several interventions such as child- and family-focused psychological strategies including Cognitive Behavioural Therapy (CBT), behavioural modification and social communication enhancement techniques, parenting

skills training and psychopharmacology. These strategies can play significant roles in the management of children with a wide range of emotional, behavioural and social communication disorders. Effective alternative educational procedures also need to be implemented for the school age children and adolescents.

In early childhood, similar parenting strategies have been found useful to manage several apparently dissimilar EBPs (*e.g.*, infant feeding or sleeping problems, preschool tantrums, disruptive and various emotional problems). This may suggest there is a common maintaining mechanism, which is probably related to poor self-regulation skills, involving the ability to control impulses and expressions of emotion.

Several studies have confirmed the effectiveness of various psychological and pharmacologic therapies in the management of childhood EBDs. A meta-analysis of thirty-six controlled trials, involving 3042 children (mean sample age, 4.7 years), evaluating the effect of psychosocial treatments including parenting programmes on early DBPs, demonstrated large and sustained effects (Hedges'g = 0.82), with the largest effects for general externalizing symptoms and problems of oppositionality and non-compliance, and were weakest, relatively speaking, for problems of impulsivity and hyperactivity.

The treatment of CD among CYP with callous-unemotional traits is still at early stages of research. The mainstay of management for CDs includes individual behavioural or cognitive therapy, psychotherapy, family therapy and medications.

Parental skills training

Any challenging behaviour from CYP is likely to elicit persistent negative reactions from many parents, using ineffective controlling strategies and a decrease in positive responses. There is evidence from published research that social-learning and behaviourally based parent training is capable of producing lasting improvement in children with callous-unemotional traits or CD, reducing externalizing problems for children with DBDs, leading to significant parent satisfaction, particularly when delivered early in childhood. These interventions are typically delivered in a group format, one 2-hour session per week for 4-18 weeks, by trained leaders, with the focus on improving parenting skills to manage child behaviour, where parents typically learn to identify, define and observe problem behaviours in new ways, as well as learn strategies to prevent and respond to oppositional behaviour.

Pooled estimates from a review of 37 randomised controlled studies identified a statistically significant improvement on several rating scales among children with CD up to the age of 18 years. A previous meta-analysis of 24 studies confirmed that Parent-Child Interaction Therapy (PCIT) demonstrated significantly larger effect sizes for reducing negative parent behaviours, negative child behaviours, and caregiver reports of child behaviour problems than did most or all forms of Positive Parenting Programme (Triple P). A recent Cochrane review of 13 studies confirmed the efficacy and cost-effectiveness of group-based parenting interventions for alleviating child conduct problems, enhancing parental mental health and parenting skills, at least in the short term.

Differentiated educational strategies

Research has focused on identifying alternative educational strategies that can be used to improve learning opportunities for children presenting with challenging behaviours from various causes. Supportive school strategies for children with EBDs have traditionally focused on classroom management, social skills and anger management, but many researchers have more recently argued that academically focused interventions may be most effective. Traditional school policies of suspending or expelling children with EBD can be harmful to them. Researchers have developed “step-by-step” guidelines for teachers to guide them in the selection and implementation of evidence-based strategies that have been identified as effective in increasing levels of engagement and achievement by children with EBD, including peer-assisted learning procedures, class-wide peer tutoring, self-management interventions and tiered intervention systems - most notably Response to Intervention (RtI) and Positive Behavioural Interventions and Supports (PBIS).

There is increasing evidence to confirm that school-based interventions to address emerging DBPs produce significant reductions in both parent-, self- and teacher-reported internalizing and externalizing symptoms.

Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH) is an educational system designed for the management of children with Autism and related communication disorders. There is some evidence that TEACCH programmes also lead to some improvements in motor skills and cognitive measures.

Best practice management strategies for children with PDA are known to differ from those with Autism. Specific guidelines for children with PDA have been published by the British institute for Learning Disabilities. Educational support for CYP with PDA relies on highly individualized strategies that allows them to feel in control. They would respond much better to more indirect and negotiative approaches. For example, “I wonder how we might…” is likely to be more effective than “Now let’s get on with your work”.

Child-focused psychological interventions

Cognitive behavioural therapy (CBT) is one of the most widely used non-pharmacologic treatments for individuals with emotional disorders, especially depression, and with individuals with behavioural problems including ASD. CBT integrates a combination of both cognitive and behavioural learning principles to encourage desirable behaviour patterns. Research evidence from several trials provide strong support for the effectiveness of cognitive–behavioural interventions among CYP with Anxiety and Depression. A recent study of child-focused CBT programme introduced at schools has shown that it produces significant improvement in disruptive behaviours among children.

Self-esteem building strategies can help many children with EBDs, who often experience repeated failures at school and in their interactions with others. These children could be encouraged to identify and excel in their particular talents (such as sports) to help build their self-esteem.

Behavioural modification and social communication enhancement strategies

Behavioural interventions and techniques are designed to reduce problem behaviours and teach functional alternative strategies using the basic principles of behaviour change. Most interventions are based on the principles of Applied Behaviour Analysis (ABA) which is grounded on behavioural learning theory. Table 5 summarizes the common behavioural modification strategies for management of childhood EBDs.

Several strategies have been designed to help children acquire important social skills, such as how to have a conversation or play cooperatively with others, using social group settings and other platforms to teach peer interaction skills and promote socially appropriate behaviours and communication. There is ongoing research in the development of social communication treatment approaches. Table 4 summarizes common social communication enhancement strategies.

Psychopharmacology of Childhood Behavioural and Emotional Disorders

Medications are often prescribed as part of a comprehensive plan for the management of childhood EBDs that includes other therapies. The greatest level of evidence for pharmacotherapy of childhood EBDs is available for their use in the management of childhood and adolescent ADHD. There is less evidence of any efficacy for medications in the management of other DBPs including ODD and CD. Table 8 lists the common classes of medications used in the management of childhood EBD.

Table 8

Major classes of medications used in management of childhood emotional and behavioural disorders**Common examplesIndications for useCommon Side-effectsFollow up monitoring**Traditional antipsychoticsHaloperidol, Chlorpromazine, Thiotixene, Perphenazine, TrifluoperazineSchizophrenia, Bipolar disorder, Schizoaffective, Disorder, Obsessive-compulsive disorder, Depression, Aggression, Mood instability, Irritability in ASDTremors, Muscle spasms, Abnormal movements, Stiffness, Blurred vision, ConstipationFrequent blood tests (Clozapine), Blood pressure checks, Cholesterol testing, Heart Rate checks, Blood Sugar testing, Electrocardiogram, Height, Weight and blood chemistry testsAtypical antipsychoticsAripiprazole, Clozapine, Olanzapine, Quetiapine, Risperidone, ZiprasidoneLow white blood cell count (Agranulocytosis - with Clozapine), Diabetes, Lipid abnormalities, Weight gain, Other medication-specific side effectsTricyclic antidepressantsAmytriptyline, Desipramine, Doxepin, Imipramine, Nortriptyline,Depression, Anxiety, Seasonal Affective Disorder, OCD, Posttraumatic Stress Disorder, Social Anxiety, Bed-wetting and pre-menstrual syndromeDry mouth, Constipation, Blurry vision, Urinary retention, Dizziness, DrowsinessWatch for worsening of depression and thoughts about suicide, Watch for unusual bruises, bleeding from the gums when brushing teeth, especially if taking other medications, Blood tests and Blood pressure checks may be neededSelective Serotonin Reuptake InhibitorsCitalopram, Escitalopram, Fluoxetine, Fluvoxamine, SertralineHeadache, Nervousness, Nausea Insomnia, Weight LossSerotonin-norepinephrine reuptake inhibitorVenlafaxine, Levomilnacipran, Duloxetine, DesvenlafaxineOther antidepressantsBupropion, Mirtazepine, TrazodoneStimulantsMethylphenidate Immediate Release and Modified Release (*e.g.*, Concerta XL, Equasym XL), Dexamfetamines Immediate Release and Modified Release (*e.g.*,

Lisdexamfetamine)ADHDDecreased appetite/ weight loss, Sleep problems, Jitteriness, restless, Headaches, Dry mouth, Dysphoria, feeling sad, Anxiety, Increased heart rate, DizzinessBlood pressure and heart rate will be checked before treatment and periodically during treatment. Child's height and weight are monitoredNon-stimulantsAtomoxetineAlpha-2 agonistsClonidine, GuanfacineDrowsiness, Dizziness, SleepinessBenzodiazepinesLorazepam, Clonazepam, Diazepam, Alprazolam, Oxazepam, ChlordiazepoxideAnxiety, Panic disorder, Alcohol withdrawal, PTSD, OCDDrowsiness, Dizziness, Sleepiness, Confusion, Memory loss, Blurry vision, Balance problems, Worsening behaviourDo not stop these medications suddenly without slowly reducing (tapering) the dose as directed by the clinician. While taking buspirone, avoid grapefruit juice, Avoid alcohol, Blood tests may be needed prior to the start of treatment and during treatmentAntihistaminesHydroxyzine HCl, Hydroxyzine, Pamoate, AlimemazineSleepiness, Drowsiness, Dizziness, Dry mouth, Confusion, Blurred Vision, Balance problems, HeartburnOther anxiolyticsBuspironeDizziness, Nausea, Headache, Lightheadedness, NervousnessSleep-enhancementZolpidem, Zaleplon, Diphenhydramine, TrazodoneInsomnia (short-term)Headache, Dizziness, Weakness, Nausea, Memory loss, Daytime sleepiness, Hallucinations, Dry mouth, Confusion, Blurred Vision, Balance problems, HeartburnBlood tests may be needed before the start of treatment. Avoid alcohol

Modified from "Medications used for behavioral and emotional disorders. A guide for parents, foster parents, families, youth, caregivers, guardians, and social workers." May 2010. Available Online: URL: . ADHD: Attention deficit hyperactivity disorder; ASD: Autistic spectrum disorder; PTSD: Post traumatic stress disorder; OCD: Obsessive-compulsive disorder.

Psychostimulants (including different formulations of Methylphenidate and Dexamphetamines) remain the primary medication of choice for management of ADHD in CYP for more than 60 years. About 75% to 80% of children with ADHD will benefit from the use of psychostimulants. Non-stimulant therapy with Atomoxetine or alpha 2-adrenergic agonists (Clonidine and Guanfacine) are also effective second-line alternative options. A recent analysis of 16 randomized trials and one meta-analysis, involving 2668 participants with ADHD, showed that both stimulant and non-stimulant medications led to clinically significant reductions in core symptoms with consistently high effect sizes. The psychosocial treatments alone combining behavioural, cognitive behavioural and skills training techniques demonstrated small- to medium-sized improvements for parent-rated ADHD symptoms, co-occurring emotional or behavioural symptoms and interpersonal functioning.

The use of pharmacological treatments for symptoms of ASD is common but challenging, as there are no medications that directly treat the social and language impairments present in individuals with ASD. The medications used most frequently include antipsychotics (*e.g.*, Risperidone) and Selective Serotonin Reuptake Inhibitors (SSRI) to treat mood and repetitive behaviour problems, and stimulants and other medications used to treat ADHD-related symptoms. The evidence base is good for using atypical antipsychotics to treat challenging and repetitive behaviours, but they also have significant side effects. Naltrexone is an opioid antagonist that has been shown from a systematic review (involving 155 children from 10 studies) to significantly improve symptoms of self-injury, irritability, restlessness and

hyperactivity in autistic children, with minimal side effects and generally good tolerance, although long-term data are lacking.

Medication use in preschool children for control of ASD and ADHD symptoms is still largely controversial. Stimulant medications for treatment of ADHD are not uniformly licensed for pre-schoolers as there is limited available research evidence to confirm efficacy and safety. Moreover, the effectiveness of parenting interventions in this age group are comparable to the effects of using stimulant drugs among the older CYP.

Research evidence from two systematic reviews and 20 randomized controlled trials has recently documented the efficacy of psychopharmacology in the management of childhood DBP. Psychostimulants have have been shown to have a moderate-to-large effect on oppositional behaviour, conduct problems, and aggression in youths with ADHD, with and without ODD or CD, while Atomoxetine has only a small effect. There is very-low-quality evidence that Clonidine and Guanfacine have a small-to-moderate effect on oppositional behaviour and conduct problems in youths with ADHD.

Other behavioural disorders in children could also be successfully treated by medications. Traditional and the newer atypical antipsychotics can be used for OCD, Depression, aggression and mood instability.

The commonest antidepressants in used in children are the SSRI and Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) medications as they work well and usually have fewer side effects compared to the older Tricyclic Antidepressants. Antidepressants can be used in the management of Major Depression, Anxiety, Seasonal Affective Disorder (SAD), OCD, PTSD and Social Anxiety. They may also be used to treat enuresis and pre-menstrual syndrome.

Conclusion

Childhood EBDs have significant negative impacts on the society, in the form of direct behavioural consequences and costs, and on the individual, in the form of poor academic, occupational and psychosocial functioning and on the family. The costs to society include the trauma, disruption and psychological problems caused to the victims of crime or aggression in homes, schools and communities, together with the financial costs of services to treat the affected individuals, including youth justice services, courts, prison services, social services, foster homes, psychiatric services, accident and emergency services, alcohol and drug misuse services, in addition to unemployment and other required state benefits.

Prevention and management of EBD is not easy, and it requires an integrated multidisciplinary effort by healthcare providers at different levels to be involved in the assessment, prevention and management of affected individuals, and also to provide social, economic and psycho-emotional support to the affected families.

There is increasing evidence base for several psychosocial interventions but less so for pharmacological treatment apart from the use of stimulants for ADHD. Preventive measures that have been researched for controlling the risk of childhood emotional and behaviour problems

include breastfeeding, avoiding second-hand smoke exposure in non-smoker youths and intensive parenting interventions.

Module 4: Fostering Self-Care, Adaptive, and Independence Skills

One of the hallmarks of successful adulting is being independent. This means being able to take care of yourself physically, emotionally, spiritually, and financially. Children with special needs often have limits that will prevent them from being able to ever live independently, even as an adult. This means we need to focus on helping them to develop the self-care and adaptive skills they can in order to have as much independence as possible. This week we will look at how to support the development of these skills so children can learn to take care of themselves.

Fostering Self-Care, Adaptive, and Independence Skills Lecture

By Elisabeth Fuller. 2022g

Self-care, adaptive, and independence skills are all part of a set of skills that most people take for granted. They refer to the skills we develop in childhood related to taking care of ourselves, meeting cultural standards, personal responsibility, and, in general, just being able to function in daily life. In general, these are the skills we learn in early childhood that help us be presentable to others, fit in with society, and live a healthy life. It is the development of these skills that help children to learn things like planning, sequencing, and organizing. These skills also help develop fine motor skills, communication, and other skills that are precursors to school related tasks.

Self-Care Skills

Self-care skills include those skills necessary to take care of oneself like personal hygiene and health:

- brushing teeth and hair
- showering/bathing
- getting dressed
- eating a healthy diet
- tying shoes
- the importance of exercise

Adaptive Skills

Adaptive skills include skills for being able to function safely in society and get along with others:

- avoiding dangers
- safe food handling
- following home, school, community rules
- managing money
- cleaning
- making friends and social skills

- developing the skills for a job

All of these self-care and adaptive skills help children to develop a sense of independence, self-worth, and personal responsibility. We want all children to be able to make choices for themselves that help them to live productive lives and feel connected to others. Children with special needs may need some extra support and time in order to develop these life skills.

Strategies and Supports

Ways that we, as early educators, can support children with special needs to develop these skills include:

- breaking tasks down into smaller steps and identifying specific areas that may give the child difficulty
- having children observe each other and family members completing these skills
- role playing or practicing on others, like getting a doll dressed
- taking care of other people
- being supportive, but stepping back and allowing children to do for themselves, even if they get frustrated
- keeping the interactions fun - if a child is having difficult holding a fork, have them pop bubble wrap instead to develop fine motor skills, for example
- simplify the skills/tasks - if a child can't tie shoes, have them wear Velcro shoes, for example

Children grow and develop at their own pace and frustration can be a deterrent to learning new things. While it is rarely best to step in and do for a child, it is appropriate to find ways to make a task easier and less frustrating. Most importantly, be creative and help the child solve the difficult tasks. This will help them be included in their own care as well as develop their own opinions, likes, dislikes, and awareness of self that helps us all to master these important life skills.

Self-Care Skills

Instructions

KidSense (2022a) discusses why self-care skills are important and how to support children in building these skills. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By KidSense. 2022a

What are Self-Care Skills?

Self-care skills are the everyday tasks undertaken so children are ready to participate in life activities (including dressing, eating, cleaning teeth). They are often referred to as the activities of daily living (ADL's). While these are typically supported by adults in young children, it is expected that children develop independence in these as they mature.

Why are Self-Care Skills Important?

Self-care skills are one of the first ways that children develop the ability to plan and sequence task performance, to organize the necessary materials and to develop the refined physical control required to carry out daily tasks (e.g., opening lunch boxes, drawing or standing to pull up pants). Self-care skills act as precursors for many school related tasks as well as life skills. The term 'self-care' would suggest that these skills are expected to be done independently and, in many cases, it becomes inappropriate for others to assist for such tasks (age dependent of course). More specifically, many preschools and schools will have a requirement for children to be toilet trained prior to starting at their centre.

When self-care skills are difficult, this also becomes a limiting factor for many other life experiences. It makes it difficult to have sleep overs at friend's or family's houses, to go on school/preschool excursions, children may standout at birthday parties if they are not comfortable eating and toileting independently, they may experience bullying or miss out on other social experiences as a result.

What are the Building Blocks Necessary to Develop Self-Care Skills?

- **Hand and finger strength:** An ability to exert force against resistance using the hands and fingers for utensil use.
- **Hand control:** The ability to move and use the hands in a controlled manner such as cutlery use for eating.
- **Sensory processing:** Accurate registration, interpretation and response to sensory stimulation in the environment and one's own body.
- **Object manipulation:** The ability to skillfully manipulate tools, including the ability to hold and move pencils and scissors with control, controlled use of everyday tools such as a toothbrush, hairbrush, and cutlery.
- **Expressive language (using language):** The use of language through speech, sign or alternative forms of communication to communicate wants, needs, thoughts and ideas.
- **Planning and sequencing:** The sequential multi-step task/activity performance to achieve a well-defined result (e.g., dressing and teeth cleaning).
- **Receptive language (understanding):** Comprehension of language.
- **Compliance:** Ability to follow simple adult-directed routines (i.e., doesn't demonstrate avoidance behaviours where the child simply doesn't want to do it because an adult is telling them to do it and interrupting what they were doing).

How Can You Tell if my Child has Problems with Self-Care Skills?

If a child has self-care difficulties, they might:

- Be unable to feed themselves independently.
- Require more help than others of their age to get dressed or undressed.
- Find it difficult to tolerate wearing certain clothes.
- Struggle to use cutlery.
- Need adults to open food packaging in their lunch box.
- Refuse to eat certain foods.
- Be unable to coordinate movements to brush teeth.
- Require extensive help to fall asleep.
- Choose to toilet only at home where there is adult support.
- Be late to develop independent day time toileting.
- Show limited motivation for independence in self-care, so they wait for adults to do it for them instead.

What Other Problems Can Occur When You See Difficulties with Self-Care Skills?

When a child has self-care difficulties, they might also have difficulties with:

- **Following instructions:** The ability to understand and be able to initiate the tasks to be done as per requested by others.
- **Receptive language (understanding):** Comprehension of language.
- **Eating:** The physical skill of using cutlery in an age-appropriate manner as well as eating a good range of food.
- **Sleeping:** Being able to independently settle and resettle to get to sleep.
- **Dressing and undressing** or assisting with dressing to an age-appropriate level and recognizing what articles of clothing go where and in what order.
- **Social skills:** Determined by the ability to engage in reciprocal interaction with others (either verbally or non-verbally), to compromise with others, and be able to recognize and follow social norms.
- **Fine motor skills:** Finger and hand skills such as opening lunch boxes, tying shoelaces, doing up buttons.
- **Gross motor skills:** Whole body physical skills using the ‘core’ strength muscles of the trunk, arms, legs such as getting on and off the toilet and standing to dress.
- **Organization:** The ability to know what a task involves, the materials required, how to collate them such as packing the bag for preschool or even getting dressed.
- **Learning new tasks** and retaining that information for the next time the task is done again.
- **Executive functioning:** Higher order reasoning and thinking skills.

What Can Be Done to Improve Self-Care Skills?

- **Visual schedule** of the steps involved.
- **Reward chart** for independent completion of tasks (or attempt at, in the early stages).
- **Small steps:** Breaking down self-care skills into smaller steps and supporting the child through each step so that, in time, they can do more for themselves.

- **Routine:** Use the *same* routine or strategy each time you complete the same task to help them learn it faster.
- **Consistency:** Be consistent with the words and signs used to assist the child and keep instructions short and simple.
- **Allow enough time:** Ensure that there is enough time available for the child to participate in self-care activities without feeling rushed (e.g., practice dressing on the weekend to start with before then doing it before rushing to preschool or school).

What Activities Can Help Improve Self-Care Skills?

- **Small parts of activities:** Practice doing a small part of a task each day as it is easier to learn new skills in smaller sections.
- **Observation:** Have your child to observe other family members performing everyday self-care skills.
- **Role play** self-care tasks such as eating, dressing or brushing teeth with teddy bears. Doing it on others can help learning it before then doing it on yourself.
- **Take care of others:** Allow the child to brush your hair or teeth first, before brushing their own.
- **Timers** to indicate how long they must tolerate an activity they may not enjoy, such as teeth cleaning.

Why Should I Seek Therapy if I Notice Difficulties with Self-Care Skills in my Child?

Therapeutic intervention to help a child with self-care difficulties is important as:

- Self-care skills are the everyday practice of the foundation's skills for academic performance not just life skills.
- The more these tasks are performed incorrectly (i.e., often daily) the more the bad habits are reinforced.
- To support age-appropriate independence before these skills become a problem such as at school camps for older children or much desired sleep overs for kind aged children.

If Left Untreated What Can Difficulties with Self-Care Skills Lead To?

When children have self-care difficulties, they might also have difficulties with:

- Reluctance to attempt not only self-care skills, but many other skills that require planning and sequencing. This is then likely to impact on academic tasks and potentially a child's transition into preschool or school.
- More difficulty resolving the difficulties as it becomes harder to change.
- Reliance upon an adult helper: A child may become accustomed to having a parent or carer assisting with self-care skills to the point it becomes an expectation, so when a helper is not there, they might display behavioural challenges.
- As the child gets older and the gap between them and their peers increases, they are more likely to become aware of this gap, resulting in lowered self-esteem and possible reluctance to attempt activities for fear of failure. This is a difficult cycle to break so the earlier it is resolved the easier it is to make forward progress.

What Type of Therapy is Recommended for Self-Care Skill Difficulties?

If your child has difficulties with self-care skills, it is recommended they consult an Occupational Therapist.

Do-It-Yourself: Using Self-Care Skills to Develop Independence

Instructions

Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Lumiere Children's Therapy. 2019

Help your child learn to independently accomplish daily tasks to develop confidence.

Feeling capable and exploring independence is a crucial component of early childhood and important for growth. Some children are eager to try new things on their own and expand their skill sets, while others are reluctant to branch out and feel insecure without the guidance of a familiar adult nearby. However, achieving tasks independently helps build confidence and self-esteem, both of which are important facets of social and emotional development.

Being able to take care of yourself is critical to a successful future, so introduce your child to independence with simple self-care tasks that will allow them to build a foundation of trust in their own abilities.

Activities of Daily Living

Self-care skills are also known as the activities of daily living, and they generally consist of small tasks that adults help young children with until they mature enough to perform these skills independently.

Self-care skills are important because they help children learn planning, sequencing, organization, resilience, and the motor skills or physical control necessary to achieve the tasks. The ability to perform these duties without assistance gives children a greater opportunity to do well in school and among their peers, and it contributes to a sense of self-confidence that has a ripple effect into other areas of life.

Practice Self-Feeding

Learning to feed themselves is one of the earliest self-care tasks most children master, and it's driven by the motivating factor of hunger. Allowing your infant to practice with finger foods helps them develop the pincer grasp along with hand-eye coordination, which are both building blocks of future self-care skills.

Once your child masters the basics of self-feeding, move on to silverware. Learning to use a spoon starts with learning how to scoop items from one container into another. Practice this skill with packing peanuts or pom-poms during playtime before moving onto food to reduce the messiness associated with learning. A bowl with a suction cup bottom can be secured to the highchair tray during practice to provide a steadier container.

Practice with a fork by placing your hand over your child's as they spear food and guide it to their mouths. Play-Doh and a plastic butter knife are ideal materials to independently practice cutting.

Perform Basic Hygiene

Bathing and brushing teeth are essential to your child's general health and well-being. While you will have to prompt and/or supervise your child's efforts to make sure they are doing a thorough job, these are great responsibilities for them to assume.

A small child will likely need to start in the tub. Start by providing them with soap and a washcloth along with instructions for washing their body from top to bottom. Once they can accomplish that efficiently, pour a small amount of shampoo in their hand and have them soap up their hair before you help with rinsing.

Brushing teeth can have lasting ill-effects if done improperly, so supervise your child closely but allow them to work on mastering this task by guiding their hand as they brush and having them watch you while you brush your own teeth.

Get Dressed

Putting on clothes each day allows offers a wide range of opportunities to practice coordination and motor skills. Start slowly by having your child choose their clothes for the day, then move on to having them put on underwear, pants with an elastic waist, and socks. As they develop

confidence navigating through those tasks, add their shirt to the routine before branching out to clothes with buttons, buckles, or zippers. Start by having your child remain seated to put on clothes so they don't have to worry about their balance and can focus on dressing safely.

Learning to tie shoes is one of the more difficult self-care tasks, but it's necessary to learn. Demonstrate the different steps of shoe-tying to your child and encourage them to practice in an unhurried pace without the pressure of an imminent departure. To make it easier, practice on a pair of shoes the child isn't wearing or with a jump rope wrapped around their legs. Start with the first few steps, then add on as they master the steps.

Although eating, grooming, and getting dressed are all basic everyday tasks, young children or children who have disabilities still need to be taught these necessities with clear instructions and the patient supervision of a caring adult. Helping your child experience independence in a safe and supportive environment is an important part of parenting and contributes significantly to their long-term success in life.

Developing Self-Care Skills in Children with Disabilities

Instructions

Bobnar (2022) provides useful information about self-care skills and how to support young children with special needs in developing these important skills. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Amber Bobnar. 2022

- **Self-care skills generally fall into the four categories: Hygiene, dressing, toileting, and feeding.**
- **There are many reasons why special needs children may struggle with developing self-care skills, from fine or gross motor limitations to sensory processing difficulties.**

- **Break down tasks into simpler parts, follow routines, and use adaptive equipment to make self-care skills easier for your child to master!**

Most children naturally develop basic self-care skills as they grow and explore the world around them. However, for children with disabilities, this process can be more challenging. While it can be tempting to do things for your child, especially when you see them struggling with a task, it's important to allow your child to be as independent as possible.

Self-care skills are important for every child to learn, but they can be especially empowering for children with disabilities. By teaching your child how to care for themselves, you're helping them to gain independence and confidence.

What are Examples of Self-Care Skills?

Four basic categories of everyday life skills, sometimes referred to as activities of daily living (ADLs), are considered a part of self-care:

Hygiene

Personal hygiene is defined as good health habits that help maintain cleanliness and protect against infection and illness. Children typically learn hygiene skills through modeling and instruction from parents and caregivers. It's important to start teaching hygiene skills early, as kids are more likely to develop good hygiene habits if they learn them at a young age.

Some basic hygiene skills that children should be taught include washing their hands properly, brushing their teeth, bathing independently, and covering their mouths when they sneeze or cough. It's also helpful to provide simple explanations of why certain hygiene behaviors are important, like explaining that hand washing can help prevent the spread of germs.

Dressing

Dressing is an essential life skill that helps children develop self-sufficiency and confidence. Learning to dress and undress not only builds independence but also gives your child a sense of personality as they develop preferences for certain colors, textures, or styles. Dressing is also an important social indicator as kids create their own style and learn to fit in with friends at school.

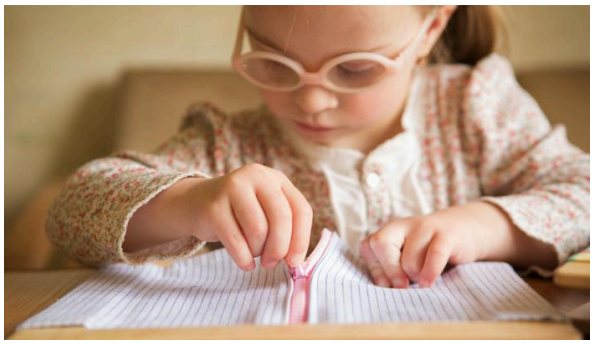
Toileting

Potty training is a basic self-care task that causes anxiety for most parents, but parents of young children with special needs can find toileting especially difficult. Learning to use the bathroom without assistance is a huge skill and a big first step toward independence. There are many factors involved in potty training a special needs child, from recognizing and communicating the need to go to the bathroom to independently standing to pull up pants. Any skills mastered while potty training is an accomplishment worth celebrating!

Feeding

Self-feeding is another basic self-care skill that can boost a child's confidence and independence. Self-feeding can also help children develop fine motor skills and hand-eye coordination.

As children age, self-feeding skills will include using different utensils, cutting food independently, making simple meals, and even packing their own lunch box for school.



Why Might Children with Disabilities Struggle With Self-Care Skills?

All kids are different and develop at their own pace, but this is even more true for kids with special needs. Depending on your child's specific diagnoses and challenges, some aspects of self help skills may be easy and others much harder to achieve.

Fine and Gross Motor Limitations

Many children with special needs and disabilities have problems with fine and gross motor development. This can impede their ability to perform everyday tasks like brushing their teeth or buttoning their shirt.

Fine motor skills involve the use of small muscles, such as those in the hands and fingers, to perform tasks like writing or picking up small objects. Gross motor skills involve the use of large muscles, such as those in the legs and arms, to perform tasks such as standing, walking, or running.

Sensory Processing Difficulties

Many children with special needs experience difficulties with sensory processing. This refers to the ability to take in, organize, and respond to information from the senses. For some children, this can mean that they are over-sensitive to certain stimuli, while others may be under-sensitive.

As a result, children with sensory processing issues often have trouble with daily living activities like eating, dressing, or bathing. In addition, they may be easily distracted or have difficulty paying attention, making it harder to learn new skills.

Limited Motor Planning

Children with special needs may also have difficulty with motor planning, meaning that they have trouble figuring out how to move their bodies in space in order to complete an action. This can be due to a number of factors, including muscle weakness, poor coordination, brain disorders, and sensory processing issues.

For example, a child with limited motor planning might have trouble putting on a shirt or bringing a spoon to their mouth because they find it challenging to plan out the specific movements necessary to complete the action. While all children go through a period of development where they are learning how to control their own bodies, children with special needs often have greater difficulty with this process.

Low Motivation

We might not want to admit it, but sometimes our kids with disabilities aren't advancing in their development because we do too much for them. It's often easier for us parents to just put on our kids' shoes, get them dressed, and feed them ourselves. And the reverse of this equation is that it's also easier for our kids to let us do things for them. Take a step back when you can and see if your child can find more motivation to learn important skills. They may surprise you!

At What Age Should My Child Master Self-Care Skills?

All children develop independence at their own rate, but it's also good to know when kids should generally achieve self-care skills and reach their developmental milestones. According to the Center for Speech, Language, Occupational Therapy, and Applied Behavior Analysis, between the ages of 18 months and 8 years, parents should see significant advances in self-care skills.

	Hygiene	Dressing	Toileting	Feeding
18 months		Following simple directions to hold out arm or leg when dressing	Showing discomfort when wet, sitting on the potty with supervision	Finger feeding small bites and drinking from sippy cup

2 years	Washing hands and brushing teeth with assistance	Removing socks, pants, shirts without fastners	Needs help getting to the potty, but having fewer accidents	Eating with a spoon, drinking with a straw
3 years	Hand washing independently, washing face	Dressing with assistance, unzipping zippers, fastening large buttons	Mostly independent on the potty, may need help with wiping and dressing	Stabbing food with a fork
4 years	Brushing teeth, washing face, brushing hair independently	Dressing and undressing independently	Fully potty trained	Mostly feeding independently, needs help cutting food
5 years	Needs help bathing	picking out clothes, tying knots and laces		Cutting food with a knife
8 years	Bathing fully independently			Preparing simple meals, packing lunch boxes independently

7 Tips for Promoting Self-Care Skills for Children with Disabilities

1. Give lots of opportunities to practice self-care tasks

When teaching your child self-care skills, it's essential to provide them plenty of opportunities to practice the new tasks they are learning. At-home or school-based therapy sessions allocate time with a professional to go over skills, but actually performing a task in real-life conditions is very different. For example, when my son was working on his walking skills, he would walk back and forth in his physical therapy sessions, but this didn't really hold much meaning for him. Having him walk from his bedroom to the dining room for breakfast, on the other hand, was much more meaningful and motivating.

Try to create a daily routine or schedule that allows lots of extra time to work on self-care. If you're focusing on hygiene, be sure to give yourself extra time in the bathroom for hand washing or cleaning teeth so your child can do as much independently as possible without feeling rushed.

2. Follow routines and a daily schedule

Speaking of routines, stick to them! Create a visual or tactile schedule for your child to follow so they know what to expect and, most importantly, what tasks they will have to complete on their own. As your child becomes more independent, the goal is that they will be able to consult the calendar themselves and finish tasks without being asked.

We've used object calendars with my son for years now, and they are great accessible tools to establish the routine for the day. Object calendars use real objects to represent tasks or activities, like a toothbrush to represent teeth cleaning or a cup to represent drinking. These objects are glued to small cardboard rectangles that can be stuck to a larger board with velcro.

You can also add large print or braille to the objects if your child is learning to read. You can make these yourself or use the Standardized Tactile Augmentative Communication Symbols Kit (STACS) from APH, which are easier to use and standardized, so your child may encounter these symbols in school or therapy sessions too. These symbols are expensive, though, so talk to your child's TVI about utilizing Quota Funds to buy them.

3. Break down a task into simpler and easier parts

Breaking down a task into simpler and easier parts can make big life skills seem less overwhelming. Occupational therapists will often suggest forward chaining or backward chaining, referring to the process of breaking up a task into small parts, then teaching the easiest part first.

For example, instead of teaching your child to brush their teeth all at once, you could break this up into

1. holding a toothbrush,
2. wetting the toothbrush,
3. squeezing toothpaste onto the toothbrush,
4. moving the toothbrush in a circular motion on the teeth.

These skills build in complexity, so this is considered forward chaining, where each skill gets more difficult and builds toward completing the task.

Some tasks begin with more refined physical control required, then build to easier movements, so in that case, you would utilize backward chaining and teach the last step first.

4. Utilize adaptive equipment when possible

There are a number of products designed to help people with disabilities complete basic self-care tasks. From adaptive utensils to three-sided toothbrushes, if it can make life easier, use it!

If your child is struggling to perform a particular task or is having difficulty tolerating certain seams or textures, there's a pretty good chance someone has created a product to help solve that problem.

5. Have necessary materials available during daily tasks

If your child is practicing a new skill, make sure that they have everything they need within reach. For example, if they are learning to brush their teeth independently, set a small toothbrush caddy on the bathroom sink with their toothbrush and toothpaste together. Make things as easy for your child as you can! If they often knock things over while performing a task, opt for containers with suction cups or magnets or add velcro to objects so they stay in place and are easily accessible.

6. Promote independence with simple materials

Who says pants need to have buttons? Or that socks need to go in a certain direction? Kids thrive on success, so make achieving success easier by choosing simpler options. We opt for elastic pants that can be easily pulled on and off and skip the buttons and zippers altogether. Seamless socks are never on backward, and round bristle hairbrushes are always held in the correct orientation. As your child masters each skill, you can move on to more complex tools, but start simple and celebrate the successes!

7. Seek help from special needs therapists

Sometimes extra practice at home can only get you so far. Look at your child's IEP or IFSP and see if you can add more hours with an occupational therapist in order to work on more self-care skills. Insurance will usually also cover outpatient sessions with a therapist in a clinic or hospital setting. Additional speech therapy services can also help as a big part of completing these tasks is the ability to communicate basic needs, such as needing to go to the bathroom. Speech therapists are often also trained as feeding specialists and can help your child develop their oral motor skills.

What is Adaptive Development and Why is it Important?

Instructions

Speech and OT (2020) provide information about adaptive development and how occupational therapists can support children in developing their adaptive skills. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Speech and Occupational Therapy of North Texas. 2020

In children, adaptive development refers to the ability level of a child related to age-appropriate life skills. These kinds of skills can be narrowly defined, such as self-care, which might include feeding and dressing. However, children develop adaptive behaviors in many areas, such as community self-sufficiency, personal responsibility, and social skills. What may be an appropriate skill at age 3 years will be very different from what might be considered optimal at 6 years of age. So, feeding oneself with one's fingers may be appropriate as a toddler, when at age 5 years, a child should be using a spoon for that same food. Adaptive development studies how a child is moving through the stages of skill development and whether that child needs assistance to stay up with their peers or meet their personal best outcomes.

Pediatric Occupational therapists are specifically trained to evaluate a child's ability to perform age-appropriate daily activities as one piece of determining a child's adaptive development level, whether that would be with self-help skills or play skills. Assessment includes observation and interaction, parent input, medical history, and the use of standardized tools. Occupational therapists evaluate fine motor precision, which looks at finger and hand movement; visual-motor integration, which examines the ability to integrate visual stimuli with motor control; balance, and coordination as well as the adequacy of sensory integration. These skills are the foundation for life skills, so by identifying strengths and weaknesses, the therapist can determine the most appropriate treatment plan for a given child.

A treatment plan is developed based on the evaluation findings. The occupational therapist will design meaningful and functional activities that will afford the opportunity for a child to learn, practice and strengthen targeted skill areas. Many times, when a skill is hard to acquire, a child (or adult!) will avoid that activity, so setting up practice situations is a critical part of treatment. Also breaking the skill into manageable steps is often very helpful. For some children, a therapist may recommend adaptive equipment, such as a pencil grip or slant board.

A key part of treatment is family training. Life skills, which are the "occupations" of daily living happen in the real world, so practicing new skills in natural environments is an important step towards successful independence. Occupational therapists typically give specific recommendations for home practice on targeted goals. For example, a therapist may provide worksheets for developing fine motor skills or may provide directions for sensory diets. Parents and caregivers need to be committed to the treatment process and carry out recommended practice to see the best success with adaptive development.

Some children will meet treatment goals more rapidly than others This typically is related to the level of the disorder. A child on the autism spectrum may need a longer period of treatment due to sensory challenges and cognitive differences. A child struggling with handwriting issues may need less treatment to meet their goals. Parent commitment to home practice is very important, however, families should know that speed of progress is most related to the child's level of challenge.

How to Promote Independence for Individuals with Special Needs

Instructions

Stanfield (2022) identifies ways to support children with special needs as they build skills for independence - without being in control of the children. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By James Stanfield. 2022

Advocating for the independence of children with special needs can be a challenging and lengthy journey. Whilst your instincts often encourage you to protect and nurture children, you may often remove many opportunities for a child to practice their independence without even acknowledging you're doing so. Encouraging children of any ability to foster a sense of independence within their lives and daily routines undoubtedly requires the attention and consistency from all of the authoritative figures in the child's life. It is this consistency, however, that can often prove to be difficult without strong communicative links between parents, carers, and professionals.

Assuming that strong communicative links between these figures are well maintained, however, embracing the commitment to support and encourage a child's independence will be a decision that will transform their lives. Before we delve deeper into the ways that this independence can be encouraged and established, it's imperative to acknowledge the positive benefits that independence can have on the life of a child with special needs. Identically to neurotypical individuals, the feeling of accomplishment and satisfaction when a task or routine has been completed for the first time without support can leave children with special needs feeling ecstatic. It is this feeling of elation that is crucial to their personal and educational development as it provides these individuals with the confidence to attempt further challenges.

For a child with special needs, the ability to live a life with minimal support from others is regularly considered to be a primary ambition. Therefore, for the purpose of making this content relatable for the demographic, we are continuing to support, the following points discuss developing independence relative to life skills, although these points are easily transferable to an array of circumstances.

Support – Aim to support a child rather than control them

An effective way to acknowledge the differences between the two actions is to recognize the definitions before translating these processes to a real-life circumstance.

To control: determine the behavior or supervise the running of.

To support: give approval, comfort, or encouragement to.

Whilst many of us instinctively seek to control situations, especially those which involve individuals experiencing limitations, mastering independence comes from having the approval, comfort, and encouragement to attempt a task alone or with limited support. An easier way to comprehend this is by accepting that one cannot learn and develop when an action is consistently acted upon for them, but rather when one is encouraged and supported to attempt the activity themselves.

It should be noted that the switch from control to support should be a gradual process that can be achieved through slight adjustments to the body language and vocabulary you present to the child. For instance, asking a child what they would ‘like’ to do, rather than what you ‘want’ them to do, eliminates the control and replaces it with a layer of care, acknowledgment, and support. It is this newly introduced element of support that will enable the child to adopt a greater sense of self-determination.

How to encourage independence within daily routines: Rather than automatically supporting a child with their personal hygiene routine, ask or prompt them to complete the task independently first. By doing this, not only are you providing them with an opportunity to succeed, but you are demonstrating to the child that this is a task that they can complete independently. This is the ‘approval’ aspect of the support definition. Next, comes comfort and encouragement where you can actively encourage the child to at least attempt the task themselves. A notably successful approach to this comes from the idea of positive reinforcement.

Integrate the independence at a slow pace

One of the most important aspects of the transition to achieving greater independence in life is that it requires a tremendous amount of patience. From the moment a child was born, to the day their special needs were initially recognized, to now; the child has been nurtured for the entirety of their lives. Rather than attempting to empower a life with independence overnight, focus on the 1% change. By making the slightest adjustments to the day-to-day living of a child with special needs, we can introduce independence much more effectively than if these alterations were popularized instantly.

Change can be overwhelming, especially for those living with special needs where consistency, routines, and rituals are regularly favored. A gradual transition to living a more independent life is of paramount importance to the successful implementation of change. Begin by introducing increased choice and slightly more limited support to everyday situations before moving onto more challenging and diverse tasks.

Allow time for change

Although the previous point touches upon the aspect of time, this section explores time from an alternative perspective. Whilst we may imply that we provide children with special needs apt time to pursue a task independently, this may not be entirely accurate. During our increasingly bustling lives, we often overlook perfect opportunities to advocate independence as we have

programmed ourselves to autonomously complete these tasks in a manner that is resourceful and efficient. Unfortunately for the children in our care, this may result in us overlooking the opportunity to offer them the previously mentioned accepting and encouraging characteristics of the support they deserve.

To eliminate this issue, we must become more mindful by actively allowing time for change. It is considered a rarity for an individual to master a skill upon their first attempt, meaning that their initial endeavors are likely to be a long and challenging process. Although we may instinctively attempt to nurture the child by quickly completing the task for them, it is essential that we provide them with the gift of time, support and encouragement.

Demonstrate positivity

Celebrate the small wins and attempts towards change! Attempting a task that has previously been out of your control can be daunting and anxiety-attracting time so my greeting their exertion with genuine praise and efforts can make this a positive experience. Pour your positive and hopeful emotions into your encouragement and build confidence as a result!

Here are the primary points for promoting independence in children with special needs:

- Empower children with the reassurance and confidence to attempt tasks with independence.
- Seek to support, rather than control the child.
- Be positive and celebrate small improvements
- Make a conscious effort to look for opportunities to encourage independence.
- Focus on the small changes rather than attempting to introduce big changes in a short time frame.

Teaching Independence

Instructions

Inclusive Teach (n.d.) provides 10 tips for helping children with special needs to develop independence skills. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Inclusive Teach. (n.d.)

It is essential we educate our children for the life they will lead as adults. For safety, wellbeing and the ability to control their direction in life. Independence will be a sliding scale for many children, but we need to enhance this wherever possible. Independence skills is a key area where parent/teacher partnership is essential.

1. Communication is Key

The core focus of any effort to enhance and encourage independence is to ensure your child has a functional communication system. In this context functional means a way to be understood by others and understand responses. A child will need to communicate their likes, dislikes, requests, questions and ask for help. Both high- and low-tech augmentative and assistive communication (AAC) systems are available to support this.

It is important that this system follows the child. Often adults who know that child well and can predict what they want will not use additional systems. This is unfair to the child as they grow. Everyone needs a system they can use with unfamiliar people. It is not about socially acceptable communication or making children speak but ensuring they can become confident communicators in different situations. If you cannot communicate basic needs and wants you cannot access places, things etc. without support.

2. Visuals, Schedules and Routines

Many children with SEN also have issues around executive functioning. This means organizing their day and required tasks or elements within that task can prove an additional challenge. Visual schedules, lists and organizers can all help. I would reinforce that the schedule needs to be for them. It is an easy trap to fall into for the adult to take ownership of putting these together each day. No!! Building a schedule of a day or task is a key opportunity to enhance both independence and give the young person more control. The idea is to reduce the amount of prompting a reminding the young person needs to complete that task.

3. Asking for help

To promote independence a person must be taught how to ask for help. This reduces frustration and increases the likelihood that a task will be completed. We ask for help all the time, it is a human action. You need to provide and model requesting help. Not as a first port of call but linked to perseverance. Recommended resources include a “help card” or structuring activities that challenge and rely on problem solving skills. Over supporting is an easy trap to fall into. By opening packets, finding resources and putting clothes away etc all you do is prove you are

better at the task than them. As long as it doesn't cause distress don't complete daily tasks for someone with the capability to do it for themselves.

Example help me cards

4. Priorities health and Hygiene

Self-care activities should be central to a child's routine both at home and school. Choosing appropriate clothing, brushing teeth, combing hair. These skills should be encouraged as early as possible in life to ensure the child both sees the value and picks up the needed skills to complete these tasks effectively. It is deficits in this area of the child's independence that can have the biggest safeguarding and child protection impacts. If a child relies on an adult to complete personal care, they are vulnerable to abuse.

5. Create opportunities within lessons

So many Life skills naturally lend themselves to being practiced at school. An independent child should be able to find the resources needed for a task in lessons. Hand washing and toilet routines are easy to build in. Timed tasks and activities give an awareness of planning for activities outside of school and into future career pathways. Colors can be taught through matching socks. Division through making Pizzas. The changes are endless.

6. It's all about the money

Learning how to use money, cash, online and card are all essential skills for all aspects of life. Money recognition, opportunities such as snack time to practice etc. Please use real coins from the start! Financial abuse is a real worry for many as they go on to supported or independent living. Teach them how to check balances, where to find trusted support. Buying online, the price of apps etc. all need to be taught to reduce the likelihood of debt as the child moves into adulthood. Independently using their money is the best way to learn.

7. Get out and about

School and other settings can create bubbles. They need to be secure and safe places to learn and develop. This can lead children to struggle when it comes to accessing community facilities, activities and shops etc. Journey planning and transport training are essential elements of this. Math lessons for older children should involve reading timetables and using apps to plan journeys. When planning an outing or trip encourage the children to arrange it. Look at the logistics and other considerations. Where possible look for amenities the children can walk to and access. Why not take the bus or walk instead of using the school minibus?

8. Introduce group activities.

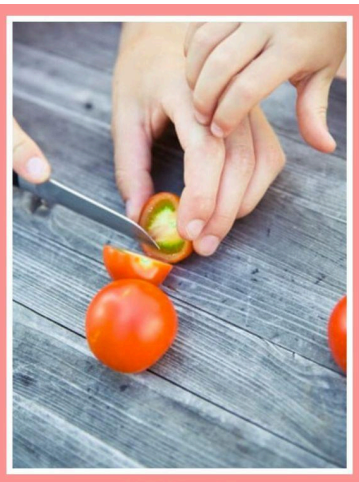
I am a great believer in not forcing social interactions on people. Finding a way to connect with others naturally can reduce dependence on an adult to lead leisure activities. Building in opportunities to share and explore special Interests can be the spark for this. Supporting staff must stop encouraging only interaction they think is appropriate. Yes, you can be sociable sharing a space, occasionally looking at what each other are doing. Group activities don't have to be structured, high energy situations. It can help to show the value of interaction. Games and shared play are better when encouraged and designed around interests rather than when forced and designed around the needs of the adults.

9. Stop hovering

Just back off and give people space to explore. If someone is always taking over or saying you are wrong you will give up, not bother. Mitigate risks by ensuring appropriate resources are supplied i.e., safe tools and cutlery then let people explore and make mistakes. That is part of learning. Okay you may like your carrots cut in batons but someone else may not.

10. Prioritize Life and Work Skills.

Many special schools already build independence and life skills into their curriculum. As children get older it is important that academic work is balanced with encouraging independence and providing the multitude of skills the child will need on leaving school. Literacy lessons should focus on following instructions, finding and evaluating information online. Writing for a purpose. The aim may not be for all to obtain employment but to provide the skills to lead a meaningful and fulfilling life. Children need to develop the skills to advocate for themselves. Recognize when they are being harassed, bullied or controlled. They need a voice, control and understanding of the world around them.



LIFE SKILLS

Teaching Independence

inclusiveteach.com

Module 5: Facilitating Social and Emotional Development

Supporting children's social and emotional development is one of the key elements of early education - it is built into every aspect of our field. When working with children with special needs, they may need more intensive support to help build relationships, understand play cues from other children, and learn how to respond appropriately when other children do interact with them. It basically comes down to being aware you may need to be even more intentional with the social aspects of the classroom and children with special needs emotional responses.

Facilitating Social Development

Instructions

Allen and Cowdery (2021d) discuss the importance of teaching young children with disabilities the social skills they need to be successful throughout life. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Eileen K. Allen and Glynnis Edwards Cowdery in *The Exceptional Child: Inclusion in Early Childhood Education (9th).* 2021d

Connections

An infant with a hearing disability smiles as her father dribbles water on her, and they both giggle.

A child in an inclusive classroom helps a child with Down syndrome figure out how to put together a floor-sized puzzle.

Wayne is sitting on a tricycle watching others play. A teacher approaches him with a wagon carrying Melissa, who has muscular dystrophy. “How about if I tie this wagon to your trike and you give Melissa a ride?”

A small group of second-grade students are writing a poem together, using facts from a story they read as a class. Teddy, a student with autism, needs adult support to participate as a member of the group.

Introduction

These are examples of social interactions that occur in early childhood settings and of how teachers, parents, and other children can facilitate the social development of children with

diverse skills. Social development depends on the individual's acquisition of the many behaviors that help people live together in a family and in society. Gordon and Browne (2010) suggest four categories for the wide range of skills children learn in the early years: The "Four Hows" are:

1. how to approach, to get in and be included;
2. how to interact, through sharing and cooperating;
3. how to deal with difference, such as teasing, bullying, including, and helping others; and
4. how to manage conflict by problem solving and handling aggression.

All children must learn these skills: those with developmental differences, those who are developing typically, and those described as gifted. How well social skills are learned depends on the quality of the interpersonal relationships in the child's everyday life. Through interacting with others, infants and young children learn the social skills (as well as the accompanying language and intellectual skills) necessary for healthy development. It is through interacting with others that young children get the necessary feedback about their social competence.

Interpersonal relationships are reciprocal; that is, there is mutual responding or turn-taking. During the early months and years, social interactions depend on the child's ability to give and receive social messages. Children with developmental disabilities may fail to respond to social signals, or they may give too few appropriate signals. Either situation reduces feedback and may lead to negative responses; both situations will interfere with emerging social development. It is not unusual for the social delays in children with disabilities to become greater than concerns associated with their primary disability (McLean, Bailey, & Wolery, 2019.

No child should be excused from learning acceptable social skills. Children who are typically developing seem to acquire social skills spontaneously or with only brief episodes of informal coaching. Children with developmental disabilities, however, often need systematic help; appropriate social behaviors may have to be taught directly, often over a considerable period of time. How teachers help these young children acquire appropriate social skills is the focus of this chapter. First, however, social skills will be examined from a developmental perspective.

Defining Appropriate Social Skills

Appropriate social skills are rules and expectations prescribed by particular groups as to how group members will conduct themselves in private and in public. Prescriptions for what is socially appropriate vary from community to community, society to society, and culture to culture.

Variations exist even within the tight circle of home, preschool, and neighborhood. Confusing choices often result, especially for young children, as in the following examples:

- Five-year-old Darryl had learned he could get almost anything he wanted from his parents and teenage brothers by throwing tantrums. The same behavior in the neighborhood and preschool did not pay off. Children taunted, "Crybaby, crybaby," and ran off, leaving him shrieking.
- Rebecca painted with obvious enjoyment during the first week of school. One day she began to cry, pointing to a small paint smudge on her sleeve. The teacher assured her it

would wash out and that the apron protected most of her dress. Rebecca would not return to the easel, even on subsequent days. What emerged were confusing social expectations between home and school: Teachers had assured Rebecca it was all right if paint got on her clothing; at home, she was scolded if her “good school clothes got dirty.”
- Chandra spent much of her time playing in the streets with older, aggressive children. There, she learned to hit, run, dodge, grab, and kick—the social skills necessary to that particular street setting. In the preschool, these same behaviors were considered socially unacceptable. Chandra had to learn to restrain aggressive behaviors at school, but to keep them ever ready when playing in the street.

These examples, described by teachers, are from real life. They point out how difficult it is to specify what is appropriate. In each instance, children were exhibiting social skills relevant to given situations in their lives. Yet they also were receiving contradictory signals about the inappropriateness of those same behaviors in another context.

Most children learn to deal with such contradictions. They find ways to adapt their behavior to various situations—a social skill necessary for all of us at every life stage. Such adaptations tend to be more difficult for children with developmental disabilities. They are likely to have trouble learning to discriminate between a behavior that is appropriate and one that is inappropriate. Trying to understand, for example, why it is all right to hug family members but not every peer in a child’s first-grade class can be confusing.

Consider the major social skills to be learned during the early years, all of which relate to getting along with others:

- Interacting with children and adults, in a variety of ways, at home and away from home
- trusting and enjoying known adults outside the immediate family
- Recognizing and protesting inappropriate advances from known or unknown adults within or outside the family
- Sometimes initiating play ideas with children; other times, following other children’s leads
- Participating in group activities through listening, taking turns, and contributing to group effort
- Sometimes putting aside individual needs and interests so the needs and interests of the group can be met
- Working and playing independently as well as cooperatively; learning to be alone without feeling isolated or rejected
- Using language as the powerful social tool it is for persuading, defending, reasoning, explaining, solving problems, and getting needs and preferences attended to

Learning social skills is a complex task involving a wide range of values, knowledge, and skills. Kostelnik, Whiren, Soderman, Stein, and Gregory (2015) describe the necessary ingredients.

- Cultural competence—knowledge of, comfort with, and respect for people of varying ethnic or racial backgrounds
- Planning and decision-making skills—the ability to make choices, solve problems, and plan ahead

- Self-regulation—the ability to monitor self, reflect on feelings, and resist temptation and peer pressure
- Interpersonal skills—maintaining friendly relationships, and communicating needs, ideas, and feelings
- Positive self-identity—demonstrating sense of competence, purpose, and worth
- Social values—exhibiting caring and demonstrating responsibility, honesty, and flexibility

Acquiring Social Skills

Social skills are learned behaviors. Learning a full range of social skills—the socializing process—cannot be forced or hurried. Learning such skills is a major occupation of the developing child. Refinement of previously learned social skills and the learning of new ones are ongoing throughout the lifespan.

Impact of Developmental Disabilities

A responsive early environment cannot guarantee a child will develop the necessary and appropriate social skills. Through no fault of parents or caregivers, children with developmental disabilities often are deprived of stimulation and reinforcement because of their disabilities. Consider these examples.

- An infant who is deaf cannot hear the crooning, loving sounds that its mother makes during bathing, dressing, and feeding routines. Thus, the infant does not make the lively responses typical of a hearing infant. The infant's lack of responsiveness reduces the mother's efforts to interact. To further compound the situation, an infant's hearing disability often goes undetected during the developmentally crucial early months. Not realizing her infant has a disability, the mother may take the infant's lack of interest in her conversation as rejection; unwittingly she may respond less positively to the child as well as less often. Social reciprocity, the give-and-take of the system, goes awry. This puts the child's social development as well as cognitive and language development at risk.
- Infants who are blind also are at high risk for poorly developed social skills. They do not engage in the mutual gaze interactions that appear to be crucial to the attachment process between parent and child. Mothers of babies who are blind often report they feel rejected when their infants do not look at them. Interestingly enough, Fraiberg (1974) noted that four-week-old babies who were blind did begin to smile, just as sighted babies did. At about two months, however, when sighted babies were smiling with increasing delight at their mother's face, babies who were blind or low vision were smiling less frequently and more tentatively. Gradually, the mothers in Fraiberg's studies on infant blindness seemed to withdraw psychologically from their babies, even though they continued to give physical care. Fraiberg's compelling example continues to hold up today.

These examples do not imply that infants and children with disabilities cannot learn appropriate social skills. Quite the contrary: They can and do. With the help of relevant members of an interdisciplinary team, parents learn to recognize alternative kinds of signaling and responding behaviors.

An infant who is blind, for example, may begin to thrash about at the sound of mother's approaching footsteps. The mother comes to value this response in the same way she would value a welcoming smile from a sighted infant. Consider another example: The infant who is deaf may snuggle in when picked up. Mother learns to respond by stroking the child rhythmically; better yet, by stroking and singing or crooning. Though the baby does not hear the singing, it usually gives pleasure to the mother. Singing also may transmit subtle vibrations from the mother's chest or throat that further stimulate the infant's responsiveness.

Overstimulation and over-responding may also interfere with an infant's ability to make use of a responsive environment. Overstimulation often occurs among fragile infants: those who are premature or very low birth weight. They are easily overloaded with too many signals coming in from the environment. Their underdeveloped nervous systems simply cannot handle the rush, and so the infant shuts down, withdraws, and may become rigid and even reject loving pats and cuddling. In a sense, the infant is "unavailable to its environment, unable to obtain information or give feedback, causing the parents and other caregivers to feel less competent and effective" (Bennett, 1990, p. 36). The opposite is true of the overresponding infant. In some instances, an infant with a central nervous system (CNS) disorder, for example, may have an involuntary rigid arm extension when attempting to turn its head into nursing position. The infant's strong-arming may be perceived by the parent or caregiver as rejection or obstinacy, a reaction that interferes with establishing a warm relationship.

These illustrations point out, once again, the need to identify a developmental disability as early in infancy as possible. Early identification, followed by appropriate intervention, is a key factor in preventing other disabilities that invariably compound the original concerns.

Developing Social Skills for Children with Special Needs

Instructions

Nature Pods (2023) gives a few strategies that can be used to support children's social development. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Nature Pods. 2023

Children with special needs often face difficulties interacting with people around them. They may struggle to make eye contact, ask and answer questions, or respond appropriately in different social situations. As they lack the skills to socialize with others, children with special needs may be overwhelmed and prefer to keep to themselves instead. Social skills guide us to respond appropriately and interact with the world around us. As such, social skills therapy is increasingly relevant for children with special needs to learn the essential skills needed in today's society.

Social Thinking

One method that is widely used is social thinking. Social thinking involves the interpreting of others' thoughts, emotions and beliefs together with the social situation – putting oneself in another person's shoes and viewing the world from their perspective. It guides them to think about the effects of their own behavior on others and teaches them the more socially appropriate way to behave and respond to different situations.

Speech Therapy

Other aspects of social skills therapy include speech therapy as well as social skills groups. Speech therapy teaches children with special needs the rules of conversation and equips them with skills to communicate with others best as they can. In social skills groups, children with special needs are encouraged to engage in simple conversation and play under the supervision and guidance of therapists. Besides engaging in conversation, social skills groups can also carry out other activities such as cooking or building Lego, where each member of the group takes on a particular role in completing the activity. A study done by Bohlander, Orlich and Varley shows that there is a greater improvement in social skills when social skills group carry out social activities together. It also suggests implementing the group in a natural setting such as the children's school, as this allows them to better generalize the skills they learn in their daily lives.

Drama Therapy

In recent years, drama therapy has emerged as a method to facilitate the learning of social skills for children with ASD. Drama therapy allows children with ASD to build on their strengths in speech imitation, as many tend to echo and repeat the words or phrases that caregivers often say to them. In this setting, children can learn to say their lines and imitate gestures as well as

body movements of others. Furthermore, children can also work on improvisation in a social setting and develop better body language and speaking skills, all of which are important skills needed when interacting with other people.

Peer Mentoring

Another possible treatment includes peer mentoring. Peer mentoring involves having a typically developing child interact with a child with ASD in a classroom setting. The peer will be taught to play and talk to the child with ASD even though he/she might not respond. This form of intervention benefits both parties, as both children learn to adapt and arrive at a common ground in order to interact with each other. As many children with special needs are attending mainstream schools today, peer mentoring is a potential alternative that can be implemented.

Nurturing the Emotional Development of Children with Disabilities

Instructions

Potgieter (2022) discusses the importance of supporting children with special needs in developing a positive self-image so they can better assimilate into the world. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Lesley Potgieter. 2022

From the moment a child is diagnosed with Cerebral Palsy or any other disability, one's immediate thought from the professionals to the parents focuses on the physical and cognitive development of the child.

What we sometimes forget is that the long-term emotional implications for children and their families living with disabilities are vast. This is true for any child diagnosed with a disability. As we focus on their cognitive and physical development, are we ignoring their emotional development?

Children with special needs need a viable resource and a safe environment where they are free to express any negative feelings surrounding their condition without repercussions. Families who are struggling to come to terms with the situation need to see they are not alone. Children often relate better to inanimate objects, like stuffed toys, where they can be free to express their emotions without criticism, and this is an approach that has numerous positive effects and spin-offs.

There comes a point in every child's life where they become acutely aware of themselves, their surroundings and their place in the world. This is no different for a child with disabilities. It is often during this time that their uniqueness is highlighted and felt more acutely and they are often left feeling frustrated, especially as there are few role models for them to aspire to. It is often left up to parents, who themselves are trying to cope, to help their child come to terms with their reality.

Children are constantly trying to assimilate and interpret the world around them. This is true for Cerebral Palsied kids as well and they sometimes find it harder to process society's view that is being projected back at them which is in many instances is vastly different from their own. It is important to assist those children by developing a positive self-image and to learn to work within the parameters of their disability rather than being defined by them.

Children being mainstreamed need help to make the transition easier. It is often not only the child that needs assistance but also the school, class and teacher. It is important to demystify any preconceived ideas by educating all those involved and changing their perception.

Often it is only those who work within the specialized field of education who are aware of disabilities like Cerebral Palsy which can make integration into mainstream schools difficult. There is a lack of knowledge and a preconceived idea of what the child with a disability is capable of achieving. There also needs to be interventions or projects that aim to change the perceptions of teachers at a training level. Teachers who do not specialize in remedial education need to be aware of changing their approach to working with the child with special needs and helping them reach long-term goals that will allow them to become productive members of society.

While much emphasis is placed on mainstream issues that normal children face, there is untapped resource in the potential of Cerebral Palsied children. By focusing and incorporating

this aspect into the development of future programs, therapists can help mold and change the outcome of the disabled children they work with.

Although children with special needs may attend specialized schools, families often feel that they are living in isolation having to deal with not only the physical implications of the disability but the social and emotional aspects too. We need to change the focus and look beyond the immediate solutions, but help families set realistic yet achievable goals that will help define and set the path for those living with disabilities and their future.

This is especially true when it comes to more rural settings where ignorance and bias is rife. Communities need to be educated and families need help to recognize that although they may feel like they live in isolation, there is a common bond that connects them with other families facing the same challenges.

Not every family has the ability to provide enough emotional encouragement that will sustain their child's development. Professionals in specialized education like physical, occupational and speech therapists also need tools to assist them to give additional support to those families that seek it.

The author, Lesley Potgieter, was born with CP and attended a specialized school before being mainstreamed in grade 7 and later qualifying as a teacher. Four years ago, she suffered a stroke which has added to her challenges. Lesley has an integral, personal knowledge of the issues she writes about. Her Aware Bears project aims at addressing many of the issues she raises.

Emotional Regulation and Special Needs: Causes, Strategies, and Skills

Instructions

The M Center for Pediatric Wellness (2020) looks at provides specific strategies to foster emotional regulation in children with special needs. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By The M Center for Pediatric Wellness. 2020

I'm excited to be talking about emotional regulation and ADHD for the next series of blogs, as they are topics extremely personal to me.

My son (almost 7) has struggled with ADHD and the emotional regulation associated with it since he was a toddler.

Of course, it's inappropriate to diagnose ADHD prior to the age of 5 or 6 because many toddler and young child behaviors mimic ADHD symptoms. However, my husband and I always knew our son's emotional responses were not typical and were a great struggle for him.

His anxiety would dominate him and he was often unable to manage his explosive emotions. I read every book on "spirited kids," "explosive kids" etc. Some things worked, but many did not.

Maturity, brain development, and working diligently on emotional intelligence and coping strategies have been most successful.

These were all implemented, of course, with dietary changes and nutritional supplementation. We have come a tremendous way, but we still have work to do so he can live the most fulfilling life.

But there is definitely hope if you have a child struggling with emotional regulation and ADHD and I would love to help you and your child manage those big emotions in those little bodies!

So, let's talk about emotional regulation…

What is emotional regulation? Emotional regulation is "the ability to respond to the ongoing demands of experience with the range of emotions in a manner that is socially tolerable and sufficiently flexible to permit spontaneous reactions as well as the ability to delay spontaneous reactions as needed," according to the most widespread definition.

If that was as confusing as Snoop Dogg and Martha Stewart's friendship, we can break it down together. In simpler terms, self-regulation skills enable us to monitor and determine what emotions we experience, act upon, and display.

No matter our age, this can be difficult for even the healthiest of people– and for children with special needs, it may seem impossible. Read on for strategies, tools, and ways to help your child's emotional regulation– built for children with special needs.

What is Emotional Regulation?

What is emotional regulation and why is it so important? Emotional regulation is important because it empowers us to choose our emotional responses and actions. Fortunately, emotions don't simply happen to us, and we can respond in three ways:

- We can initiate actions triggered by emotions. (Not ideal).
- We can inhibit actions triggered by emotions. (Also not ideal).
- We can modulate responses triggered by emotions. (Best choice)!

We can choose what emotions are important out of the countless emotional stimuli we receive each day. and we use our emotional regulation skills to respond in ways that help, not harm, us.

While we all learn this skill, it may be a bit more difficult for children struggling with an anxiety disorder, PANDAS, learning disability, ADHD, or other special needs. We already know that they may be more likely to struggle with negative feelings and poor self-esteem.

In one promising study, children who were taught emotional regulation skills received 46% less disciplinary referrals at school in just four months. Properly managing emotional reactions can affect a child's life in a positive, meaningful way.

Emotion regulation strategies can be taught, and learning these skills can increase a child's well-being, positive emotions, and ability to choose responding over reacting.

Emotional Regulation Strategies in Childhood Development

All of this information may leave you wondering: how do you emotionally regulate?

There are many strategies of how you can emotionally regulate in childhood development. Here are the major strategies for improving a child's regulation processes, though it should be noted that not all are equally helpful or positive:

Dialectical Behavior Therapy (DBT) is a psychotherapy technique used to help individuals improve their distress tolerance, control negative thoughts, understand and moderate their emotions, improve quality of life, and set goals for the future.

DBT involves both individual therapy and group work. The emotion regulation skills taught include:

- Being aware of both positive and negative emotions, and how to identify them.
- The ability to name and label emotions.
- Self-awareness about one's current feelings.
- Knowing and using desirable reactions in everyday life.
- Improved ability to manage stress and use positive coping techniques.

DBT is often not implemented until a child is 10 or older.

Cognitive Behavioral Therapy (CBT or cognitive therapy) may help children with anxiety worry less and increase their emotional awareness. However, this and other studies express concern that it does not affect regulation of other emotions like anger or sadness.

Situation selection refers to the strategy of keeping the child away from situations that will be harmful or negatively impact their emotional experience. This is about helping a child learn to choose what situations they place themselves in, considering their own reactions in advance.

Situation modification is the term used for the attempt to change the emotional tone of a situation, whether through physical distancing, humor, changing the subject, or another method.

Exercise can be effective in decreasing perceived stress and emotional distress in just two months, according to one study (not to mention, getting active improves a child's physical health)!

Attentional deployment can take many forms of redirecting attention either toward or away from an emotionally charged situation. This may look like:

- Distraction — while this isn't a long-term option for helping your child's emotional regulation, short-term distraction may temporarily help with emotion dysregulation.
- Other methods include worry, rumination, and thought suppression, all of which are "maladaptive," or have negative results over time.

Cognitive change is a way of changing how the child processes the situation so as to alter its meaning in their mind. This can be done through:

- Reappraisal, in which an individual reinterprets a situation or event to give it a new emotional meaning. In most cases, this is considered a positive strategy. For example, something that a child previously thought was "the end of the world" is now just a bad day at school.
- Distancing, referring to a child's ability to remove oneself from the situation and see things objectively, can be quite helpful. In fact, it's been shown to decrease negative reactions, heart rate, and blood pressure when used as a strategy.
- Good-natured positive humor can help with emotional regulation, but negative humor does not have the same results.
- Biofeedback may be used to train the brain to recognize the emotional component of decision making, which helps improve decision quality and reaction times. A review of biofeedback strategies using serious games found that, across 16 clinical trials, the improvements in emotional regulation were significant.

As you can see, there are a myriad of strategies for helping your child cope positively with their feelings. You don't have to live with a tiny version of Bruce Banner/The Hulk!

How to Foster Emotional Regulation with Children

How do we foster emotional regulation with children? As a parent, you likely know that huge positives can happen at home. (If you don't know how much you impact your kids, check out This Is Us and bring some tissues).

What are emotional regulation skills? Emotional regulation skills help people handle and express their emotions. They should be taught within the family, and there are many age-appropriate options that you can do with your little one to walk them through processing their feelings:

- Show and tell — don't just tell your child how to self-regulate, show them with your own behavior! Children often model what they see at home. When you display positive coping strategies, they see a practical example to follow.

- Take five — ask a child to delay his or her response instead of reacting immediately. Studies show that taking a break and completing a distraction task can lessen the severity of a response.
- Top the charts — when children don't have adequate emotional vocabulary, it is difficult for them to articulate their needs and struggles. Creating a feelings chart is one effective way to help them decipher, explain, and regulate their emotions. You may even want to equip family members with this tool, empowering them to help your child have conversations about feelings. It takes a village!
- Cause and effect — clarifying consequences, especially for children with special needs, eliminates guesswork for them. Whether it's chores and rewards or tantrums and losing their Xbox privileges, create clear consequences so they can understand the impact of their choices and behavior. Talk these scenarios through with them.
- Breathwork — this brings them to the present moment and brings them to their body. Additionally, breathwork can benefit both mental and physical health.
    - Ask your child to take slow breaths and count to 5 to inhale, and then 7 to exhale. Repeat until they feel more calm.
    - Encourage your child to put one hand on the heart and one on the belly, noticing how they each rise and fall differently during deep breaths.

Your friends, family, and support network may benefit from you sharing a few of these techniques. A reminder to be compassionate and use these tools is never amiss.

A Functional Approach to Special Needs

If you're here and reading this article, it's likely because you want to do everything possible to help your child!

We have been in your shoes, and we understand. While we highly encourage therapy in most of our cases, we have a few other recommendations up our sleeve:

- Diet and nutrition — children with special needs tend to be picky eaters and to have more food allergies than others. A natural, gluten- and dairy-free diet will likely work wonders, as will an allergy test and nutritional assessment to determine their needs. Removing gluten and dairy was a game changer for my son!
- Removing toxins — many children with special needs also have high concentrations of heavy metals, pesticides, or other toxins in their system.
- Improving immune function and removing pathogens — stress can actually take a toll on the immune system, and the microbiome of children with special needs can also need some help.

It's not easy dealing with emotional regulation challenges in children, and it's important to talk to healthcare practitioners who understand.

Emotional Regulation Disorder

What is poor emotional regulation? Poor emotional regulation can cause problems in reactions and judgement, friendships, work, school, and stress management.

In emotional dysregulation, negative emotions can run amok and dramatic responses are common.

However, a more intense condition can be known as emotional regulation disorder or borderline personality disorder. Individuals with this disorder can present exaggerated, impulsive emotional reactions.

These may look like fits of anger, accusing, crying, hysterics, accusations, emotional instability, insecurity, and feeling worthless. DBT, a treatment mentioned above, is also an empirically supported, effective treatment for borderline personality disorder.

Emotional Regulation Skills in Healthy Adults

You're the adult here, but you're still human. How do you emotionally regulate? You can emotionally regulate by using any of the strategies or exercises mentioned above!

Furthermore, you may try mindfulness, gratitude journaling, engaging in a hobby, or building a support network of friends, family, and professionals. It's never too late to start learning how to regulate your emotions.

Looking to the Future

The future is bright when it comes to empowering your child (or yourself) to regulate emotions. These skills can be learned with practical tools and good modeling in your home, and will improve your child's world and relationships.

One final note: you are doing a great job parenting your child with special needs! While it's a rewarding task, it's not always an easy one. In all this talk of emotional regulation, don't forget to take the time to notice your own feelings, too.

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Social-Emotional Learning and Positive Behavioral Interventions and Supports

Instructions

The CDE (2019) has provided guidelines for the socio-emotional learning of young children. Remember to take notes on the resource since you are required to cite sources in the assignments for the course.

Learning Resource

By California Department of Education. (2019). *California practitioners' guide for educating English learners with disabilities*. Sacramento, CA; California Department of Education.

California is united in its affirmation of social-emotional learning as an essential part of well-rounded, quality education in all settings serving children and youth. The Collaborative for Academic, Social, and Emotional Learning (CASEL) defines social-emotional learning as "the process through which children and adults acquire and effectively apply the knowledge, attitudes, and skills necessary to understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and

make responsible decisions." CASEL identifies five interrelated sets of cognitive, affective, and behavioral competencies that contribute to social-emotional learning:

- self-awareness
- self-management
- social awareness
- relationship skills
- responsible decision-making

The California Department of Education, in collaboration with statewide partners, established Guiding Principles designed to build on the social and emotional learning (SEL) practices already happening in many schools and to promote the intentional use of evidence and research-based practices to guide decision-making.

- **Adopt whole child development as the goal of education.** Take a systems approach to promoting student academic, social-emotional learning, physical well-being, and college, career, and civic life readiness. Name SEL as a must have (not a nice to have) to ensure student success in school, work, and community.
- **Commit to equity.** All students must have opportunities to build SEL skills and receive an assets-based educational experience that is personalized, culturally relevant and responsive, and that intentionally addresses racism and implicit bias. Use practices that build on the existing strengths of students, educators, families, and communities.
- **Build capacity.** Build the capacity of both students and adults through an intentional focus on relationship-centered learning environments and by offering research-based learning experiences that cultivate core social-emotional competencies.
- **Partner with families and communities.** Maximize the resources of the entire school community, including expanded learning opportunities, early learning and care programs, and family and community partnerships to advance SEL and student well-being.
- **Learn and improve.** Adopt continuous improvement practices and use evidence to guide decision-making while aiming to enhance the quality of student social-emotional learning opportunities. Use data to inform improvement of instructional and school practices, not for accountability purposes.

Schoolwide Positive Behavioral Interventions and Supports (SWPBIS) is a systemic change process for an entire school or district where behavioral expectations are taught in the same manner as any core curriculum subject. For example, schools might focus on the following positive behaviors:

- Respect Yourself and Others
- Be Responsible
- Build Relationships

SWPBIS emphasizes constructive interventions as an alternative to punitive discipline, which has disproportionately and negatively affected students of color, including English learners with disabilities. The framework has the potential to reduce school exclusion by appropriately matching the severity of the disciplinary incident to the consequence.

For more guidance on social-emotional learning and Positive Behavioral Interventions and Supports (PBIS), see chapter 2 of this guide. Additional SEL and PBIS resources can be accessible at the following websites:

- The Collaborative for Academic, Social, and Emotional Learning (CASEL)
- Positive Behavioral Interventions and Supports Office of Special Education Programs (OSEP) Technical Assistance Center
- SWIFT Guide on PBIS
- The Wallace Foundation: Navigating SEL from the Inside Out
- Edutopia—Social and Emotional Learning
- Mindset Scholars Network
- A Framework for Safe and Successful Schools11
- National Education Association—Freeing Schools from the School to Prison Pipeline
- Teaching Tolerance—The Building Blocks of Positive Behavior

Module 6: Facilitating Speech, Language, and Communication Skills

Speech, language, and communication skills are important for learning, social interactions, and getting our needs met. In the early childhood classroom, it is important to have an environment that encourages children to talk and also has many novel activities and experiences available, so children have something to talk about. While support speech and language are important for every child, there are specific challenges with children with special needs.

Facilitating Speech, Language, and Communication Skills Lecture

By Elisabeth Fuller. 2022e

While our ultimate goal is always to have children express themselves verbally, working in early education there will be children who develop verbal skills slower or not at all. It becomes important to be aware of a variety of different communication strategies that support children in learning and expressing their ideas and needs.

Alternative Language Systems

Non-Verbal Communication

As early educators we need to be aware of the non-verbal expressions children communicate: shrugs, scowls, smiles, flinches, looking away all are ways of communicating. While we want to support children in expressing their needs, likes, and dislikes verbally, we also need to pay attention to their non-verbal cues. We can use a child's non-verbal cues to assist in modeling verbal communication, for example, if we see a child flinch away from another we can say, "When Jason pushes you, say, 'Stop it!'"

Unaided Communication Systems

Unaided communication systems refer to the use of a child's body to communicate needs and desires. For example, body language, sign language, and gestures can be used to understand what a child is trying to say.

Aided Communication Systems

Aided communication systems use tools, books, pictures, etc. to communicate a child's needs and desires. Examples include simple tools such as paper and pencil, as well as communication books, picture exchange systems, as well as more high-tech devices that produce voice output (speech generating devices or SGDs) and/or written output. Some devices can be programmed to produce different spoken languages. The newest devices include computer tablets, which provide the user with the opportunity to access special apps that use picture symbols, letters, and/or words and phrases to communicate.

For preschool children, intelligibility is important, meaning can the child and the people in the child's environment understand the system. Usually sign language or a picture/symbol exchange is used to support a preschool child with special needs since they often don't have the fine motor skills necessary for many of the aided systems. Systems that require the child to hand a picture to an adult to communicate are more effective than pointing to a picture since the request is clearer and more difficult to miss or ignore.

What is most important with these systems is that they are used consistently throughout the various environments where the child interacts with others. The consistency, especially in the early years, is what helps children to develop language and communication skills. While it is important for teachers to understand whatever system is used, it is also important to teach the peers in the classroom how to use the system. Most importantly, though, the teacher will need to make specific plans for the children to engage with the child with special needs using the communication system.

Here are some suggestions from teachers on how to help peers engage with each other:

- Assign students who use AAC a classroom job that would require them to ask questions of peers.
- Teach students to count to ten to make sure they are providing plenty of time for a response from the peer using AAC.
- Show the class YouTube videos of AAC communication devices, sign language, and picture exchange communication systems.
- Have a child who uses AAC demonstrate to the class.
- Provide all students an opportunity to interact using AAC devices. Discuss the barriers that might occur.
- For older students, read a play and assign each student a role to facilitate turn-taking (Allen & Cowdery, 2022).

Teacher Expectations in a Language Learning Environment

As the teacher in the classroom, it is important that you arrange the learning environment to give children many different opportunities to talk. This means that children are expected to communicate and also have many reasons to communicate. This allows for a relaxed atmosphere where language is an integral part of the classroom. Teachers can work at being good listeners who respond with open-ended questions, providing enough time for children to formulate their thoughts and responses. It is important to ask open-ended questions and to facilitate and prompt children by reflecting children's thoughts back to them and helping them to formulate an answer.

If a child turns away without responding, the conversation is basically ended. If this happens frequently with a child, the child is losing out on language play and practice as well as the necessary information most children get through everyday verbal exchanges. Children will need assistance in maintaining communication in free play. Adults should not talk excessively to children, but they do need to be responsive when children initiate interactions.

Activities to Talk About

Children need to have many things to talk about. There need to be new experiences presented in the classroom for children to be curious and ask questions about. Books and other learning tools need to be available as well as games, songs, dramatic play centers, etc. with curriculum that is changed regularly to reflect new themes and learning opportunities. Activities that promote fine and gross motor skills are especially important in supporting children in communicating with peers.

Theories of Speech and Language Development

Instructions

While this week we are talking about supporting children's communication skills, I think it is important to first have a refresher on how children acquire language. De Benedictis (n.d.) provides a decent summary of language acquisition and how these theories can be applied. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Alexa De Benedictis. n.d.

Objectives:

1. Understand each of the four theories of language development.
2. How do clinicians apply the theories of language development?
3. Be familiar with the multicultural considerations of speech and language development.

The process of speech and language development in infants and children is complex and interrelated. For normal communication to develop, there must be an integration of anatomy and physiology of the speech systems, neurological development, and interactions that encourage infants and children for communication attempts. Language development includes both receptive and expressive language. (Owens, 2012) There are four theories that explain most of speech and language development: behavioral, nativistic, semantic-cognitive, and social-pragmatic.

Understanding the Theories

Behavioral Theory

The behavioral perspective states that language is a set of verbal behaviors learned through operant conditioning. Operant conditioning is a method of changing behavior so that a desired behavior is reinforced immediately after it occurs. B.F. Skinner is considered to be the father of

the modern behavioral theory. This theory can be applied to many aspects of human learning including speech and language. The theory centers around the idea that children are conditioned by their environment and the reinforcement of their communication.

Behaviorists believe that language behaviors are learned by imitation, reinforcement, and copying adult language behaviors. They consider language to be determined not by experimentation or self-discovery, but by selective reinforcements from speech and language models, usually parents or other family members. Behaviorists focus on external forces that shape a child's language and see the child as a reactor to these forces. (Hulit, Howard, &Fahey, 2011)

Imitation and Practice

Two other concepts that are important for understanding the behaviorist ideas of speech and language development are imitation and practice. A young child will try to imitate sounds and words he hears his parents say the best he can. When a child says a word that sounds close to what the parents say, they accept and reinforce it. In other words, they begin shaping the word until the child can eventually say the word as well as the parents do.

An example of selective reinforcement:

A child says "mama" when his mother starts to pick him up. The mother is delighted to hear the child say this and gives the child a hug and kiss. The mother says "Mama, that's right, I'm Mama!" The mother's affectionate response makes it more likely that the child will say "mama" again. The mother's response to the child reinforced the behavior.

Nativistic Theory

The nativistic theory is a biologically based theory which states that language is innate, physiologically determined, and genetically transmitted. This means that a newborn baby is "pre-wired" for language acquisition and a linguistic mechanism is activated by exposure to language. (Hulit, Howard, & Fahey, 2011). This theory believes that language is universal and unique to only humans and that unless there are severe mental or physical limitations, or severe isolation and deprivation, humans will acquire language. The nativistic theory argues that caregivers do not teach children the understanding of language and do not usually provide feedback about the correctness of their utterances. (Pinker, 1984).

Language Acquisition Device

The main theorist associated with the nativist theory is Noam Chomsky. He came up with the idea of the language acquisition device (LAD). The LAD is a language organ that is hard-wired into our brains at birth. Once a child is exposed to language, the LAD activates. Click the button below to learn more about Chomsky's ideas.

The Nativist Perspective

Semantic-Cognitive Theory

The semantic-cognitive theory is a perspective of language development that emphasizes the interrelationship between language learning and cognition; that is, the meanings conveyed by a child's productions. Children demonstrate certain cognitive abilities as a corresponding language behavior emerges. (Bloom & Lahey, 1978). The semantic meaning that a person wants to communicate determines the words and word order (syntactic form) the person uses. For example, children know what they want to communicate (cognition) but do not always use the correct semantics or grammar. Also, children may not know the correct use of a word or understand that a word can have more than one meaning.

Social-Pragmatic Theory

The social-pragmatic theory considers communication as the basic function of language. This perspective is first seen in infant-caregiver interactions in which the caregiver responds to an infant's sounds and gestures.

The prerequisites for the social-pragmatic theory are:

1. The infant must have a caregiver in close proximity to see, hear, or touch.
2. The caregiver must provide the infant with basic physical needs such as food, warmth, and exploring the environment.
3. The infant must develop an attachment to the caregiver.
4. The infant and caregiver must be able to attend to the same objects or actions simultaneously.
5. The infant and caregiver engage in turn-taking in both verbal and nonverbal behaviors (McLaughlin, 2006).

In ideal parent-child communication, all of the five prerequisites are met in most interactions. The social-pragmatic perspective emphasizes the importance of the communicative partner's role; the partner's interpretation of what is said defines the results of the speech act.

How do Clinicians Apply These Theories?

Behavioral Theory

For decades, clinicians have used a behavioral approach to study children's language by observing, describing, and counting specific language behaviors. This basic stimulus-response model first teacher children to imitate a sound and then reinforces the sound production with verbal praise (e.g. "Great job!"). The children's sounds are shaped into increasingly closer

approximations of the target sound, and when they finally are able to produce the target sound correctly, the sound is practiced in a variety of word and sound combinations.

Nativistic Theory

When children do not use certain language structures that are appropriate for their age, they most likely have not acquired them naturally and would need to improve in therapy. Helping children learn how to combine words, phrases, and sentences lets them convey messages to others. Instructing children about how to use language appropriately in different social situations and environments allows them to use appropriate pragmatics when communicating.

Semantic-Cognitive Theory

Clinicians use the semantic-cognitive theory by describing children's strategies for gaining new information. For example, the complexity of a sentence, the amount of information in the sentence, and the rate at which the sentence is said may significantly affect the way a child understands a sentence. A child with delayed or disordered language could benefit from a clinician who can adjust one or all of these variables. A clinician may be able to make a sentence simpler with less information for a child to process and slow down the rate of speech so that the child can better understand the message.

Social-Pragmatic Theory

Caregivers can make language easier in many ways, including playing social games that are stimulating and exciting for infants (e.g., peekaboo), taking turns in activities where the caregiver speaks and expects the infant to respond in a similar way, and reading books with young children. Clinicians can assess and treat a child's language impairments from a social-communicative and contextual perspective. The goal of therapy is to maximize the child's ability to communicate.

Cultural and Linguistic Diversity Perspective

Although not necessarily considered a theory of language acquisition, clinicians need to be aware of cultural and diversity perspectives. Regardless of the theory of language development that is followed, children mature and grow within the context of their caregivers, whether they are parents, family members, or other members of the community. These people provide an environment with communication for the maturing child that reflects the range of meanings, values, perceptions, and beliefs of the cultures they are a part of. The United States is considered multicultural, like many other countries. Multicultural refers to a society that is characterized by a diversity of cultures, languages, traditions, religions, and values, as well as socioeconomic classes, sexual orientations, and ability levels where, ideally, individuals are respected and valued for their contributions to the society as a whole. Speech-language pathologists and audiologists need to be able to understand and appreciate the cultural-linguistic diversity of client populations in order to better serve them. (Owens, 2012)

Cultural diversity is not determined by a person's origin or color of skin, but by many other factors including linguistic background, level of education, socioeconomic status, and religious beliefs. Any of these factors could influence speech and language development. Many children in America are come from families who have recently immigrated to America. These families often continue to speak their native language at home and in social environments. This typically causes children to develop the family's native language as their first language. However, many children may be exposed to both their native language and English and will learn to speak English with an accent.

Dialects

There are approximately 1,000 languages in the world spoken by at least 10,000 people. (Crystal, 2010). Languages have a variety of forms and dialects that can vary in phonology, vocabulary, and grammar. Within a language, no dialect is better than another, however, standard dialect can be associated with higher education levels and is used in education environments. Standard dialects for one language can even vary from country to country. For example, America, England, Australia, New Zealand, and Singapore all use English, but have very different dialects.

ASHA (1998) provided a statement about speech-language pathologists working in school settings who have different dialects than the community. "ASHA maintains that members may not discriminate against people who speak with a nonstandard dialect in educational programs, employment, or service delivery. However, clinicians must have the necessary diagnostic and clinical skills and be able to model required treatment targets. In addition, the clinician may not have limited English proficiency."

Stages of Language Development Chart

Instructions

Kid Sense (2022b) provides an overview chart of language acquisition - more of a quick reference for 0-5 years old. What I like about it is the last column: Possible Implications if Milestones not Achieved. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Kid Sense. 2022b

There are two main areas of language:

- **Receptive language (understanding):** Comprehension of language.
- **Expressive language (using language):** The use of language through speech, sign or alternative forms of communication to communicate wants, needs, thoughts and ideas.

Note: Each stage of development assumes that the preceding stages have been successfully achieved.

See the Appendix beneath for explanation of terms.

Age	Listening	Vocabulary	Sentences	Verbal grammar	Concepts	Questions	Possible implications if milestones not achieved
6-12 months	Attends to sounds and voices Recognises facial expressions and tones of voice	Babbling (e.g. ma-ma, da-da) Takes turns vocalising with others Recognises names of a few objects	No specific milestones	No specific milestones	No specific milestones	No specific milestones	May have difficulties socialising with parents and joint attention May affect muscle tone in the face as babbling helps to strengthen the muscles

1-2 years	Responds to familiar requests (e.g. come here) and own name Understands gestures (e.g. wave for 'bye')	Babbling (e.g. ma-ma, da-da) Takes turns vocalising with others Recognises names of a few objects	No specific milestones	No Specific milestones	No Specific milestones	Can understand one key word in a sentence (e.g. Where's your **nose**?)	May have difficulties socialising with parents and joint attention May struggle to copy and learn from others due to poor understanding and attention
2-3 years	Follows 2 part instructions (e.g. Go to your room and get your shoes) Points to main body parts, clothing items, toys and food when asked	Names actions (e.g. go, run) By 2 years vocabulary is 250-300 words By 3 years uses 1000 words	Minimum of 2-3 words in a sentence (e.g. Daddy go work Still talks to self in long monologues	Talks about present events **Regular Plurals** e.g. 1 dog, 2 dog**s** **Articles** –'a' and 'the' **Progressive –ing** – e.g. The boy is jump**ing** Uses **Pronouns** – **'you, I, me, mine'** **Regular Past Tense** – e.g. "I climb**ed**" **Possessive 's** – e.g. "Daddy**'s** car	**Position:** on; off; in; out; up; down; under; top; open; shut **Size:** big; small/little; long **Quantity:** 1; 2 **Other:** stop; go/start; loud; quiet; heavy; soft; fast; hot; cold	Understands and asks **What** and **Where** questions	May have difficulties socialising with peers and joint attention May struggle to copy and learn from others due to poor understanding and attention May have difficulties following instructions May have difficulties being understood by peers May have difficulties being understood by unfamiliar people May have difficulties expressing wants, needs, thoughts and ideas

3-4 years	Follows 3 part instructions (e.g. point to the cat, the dog and the monkey Understands longer, more complex sentences	By 4 years uses nearly 1500 words	Minimum of 3-4 words Tells you what they are doing Tells you the function or use of an object	Begins to talk about past events **Auxiliary 'is'** – e.g. The girl **is** skipping **Pronouns 'he/she'** – e.g. "**He** is running" or "**She** is drinking". **Connector 'and'** –e.g. "I want a banana **and** an apple" **3rd Person Singular** – e.g. "He want**s** the ball"; "It eat**s** grass"; "She read**s** books" **Contracted Negative** – e.g. isn't, doesn't, haven't, shouldn't **Contracted Copula** – e.g. He**'s** happy **Past Participle** –e.g. It's brok**en**	3 to early 4 years: **Position:** bottom; behind; first; near **Size:**short (length) – emerging; short (height) **Quantity:**3; every; none **Other:**hard; slow; light (weight); many colours	Understands **Who** questions Asks **What, Why, When** and **How** questions	May have difficulties socialising with peers May struggle to copy and learn from others due to poor understanding and attention May have difficulties following instructions at home, child care, kindergarten May have difficulties being understood by peers May have difficulties being understood by unfamiliar people May have difficulties expressing wants, needs, thoughts and ideas May have difficulties responding appropriately to questions Word finding difficulties causing disfluent speech

4-5 years	Follows the meaning of others' conversations	Continuing to expand Can generally understand colour and shape words (e.g. red, square) Can sort objects into simple categories (e.g. animals, food)	Minimum of 4-5 word sentences	Talks about past and future events **Pronouns 'his, hers, theirs'** – e.g. "It is **his/hers/theirs** " **Comparative –er and Superlative -est:** e.g. big, bigg**er**, bigg**est** **Use of 'is' vs 'are**' – e.g. "The monkey is eating a banana" vs "The monkeys are eating the bananas") **Past Tense "to be"** – e.g. "I **was** running" and "They **were** running" **Connector 'because**' –e.g. The boy was crying **because** he fell over and hurt his knee" **Adverb –ly** – e.g. quick**ly**, slowly, quiet**ly** **Irregular Plurals** – e.g. mice, men	**Mid-late 4 years:** **Position:** middle; around; away from; between; through; next to/beside; last **Size:** short (length); short (height); tall; fat **Quantity:** 4; most; few **Late 4-5 years:** **Position:** in front; in a line; corner; middle **Size:** thin **Quantity:** 5 (emerging); pair **Other:** same; different (size); different (function)	Understands **How** questions Asks meanings of words	May have difficulties socialising May struggle to copy and learn from others due to poor understanding and attention May have difficulties following instructions at home, kindergarten May have difficulties being understood by peers May have difficulties being understood by unfamiliar people May have difficulties expressing wants, needs, thoughts and ideas May have difficulties responding appropriately to questions Word finding difficulties causing disfluent speech

5-6 years	Follows the meaning of others' conversations Follows multi-step instructions Vocabulary comprehension increases	Vocabulary comprehension increases	Uses more complex sentences Uses imaginative language in play – likes to pretend and act out stories Tells several attributes about an object	**Irregular past tense** – e.g. fell, broke, ate	**Time:** yesterday, tomorrow, morning, afternoon, later	Uses **How and Where** questions	May have difficulties socialising May have poor attention and concentration May have difficulties following instructions at home, school May have difficulties retelling events May have difficulties following routines May have difficulties being understood by unfamiliar people May have difficulties expressing thoughts and ideas verbally and in written form May have difficulties responding appropriately to questions Word finding difficulties causing disfluent speech

6-7 years	Ideas are shared Follows multi-step instructions	Can classify objects according to more specific traits (e.g. form, colour, use or composition- what it is made of)	Gives short oral reports Uses language at a higher level to make jokes, tease, engage in sarcasm, argue point of view, explain complex situations, talk about movies or past events in detail Develops written language skills and ability to write descriptive paragraphs and stories	Grammar is mature	Position: left; right Other: same; different; season; time of day Can understand the difference between reality and fantasy	Able to make predictions, justify decisions, provide solutions and give explanations	May have difficulties socialising May have poor attention and concentration May have difficulties following instructions at home, school May have difficulties retelling events May have difficulties being understood by unfamiliar people May have difficulties expressing thoughts and ideas verbally and in written form May have difficulties responding appropriately to questions Word finding difficulties causing disfluent speech May have difficulties with reading fluency and comprehension

7-8 years	Can listen for a sustained period of time (e.g. attend to a guest speaker at school)	No specific milestones	Can express their opinion Can retell both imaginary and real events	Uses appropriate grammar in their speech and written work	Can problem solve	Will ask questions to clarify information	May have difficulties socialising May have poor attention and concentration May have difficulties following instructions at home, school May have difficulties retelling events May have difficulties problem solving May have difficulties expressing thoughts and ideas verbally and in written form May have difficulties responding appropriately to questions Word finding difficulties causing disfluent speech May have difficulties with reading fluency and comprehension

Appendix

Grammar Explanations

Regular Plurals – adds a ‘s’ to the end of words to represent more than one (e.g. 1 dog, 2 dog**s**)

Articles – learns to use the words ‘a’ and ‘the’ (e.g. “I would like **a** piece of fruit please” or “I would like **the** blue lolly please”)

Progressive –ing – adds **–ing** to the end of verbs (e.g. The boy is jump**ing**)

Uses **Pronouns ‘you, I, me, mine’** – e.g. “What are **you** doing?”; “**I** am happy”; Adult: “Who wants a lolly? Child: **Me!**; “That’s **mine**”

Regular Past Tense – learns to put **ed** on the end of verbs to represent that something has happened earlier. This tends to be used for all verbs even if it requires an irregular past tense (e.g. “I runn**ed**” instead of “I ran”)

Possessive ‘s – learns to put an **‘s** on the end of nouns (i.e. naming words) to indicate possession (e.g. “Daddy**’s** car”)

Auxiliary ‘is’ – learns to include the “helping verb” ‘is’ in a sentence (e.g. The girl **is** skipping)

Pronouns ‘he/she’ – learns that when talking about males we use the pronoun ‘he’ and when talking about females we use the pronoun ‘she’ (e.g. “**He** is running” or “**She** is drinking”)

Connector ‘and’ – learns to join two small sentences together using the word ‘and’ (e.g. “I want a banana **and** an apple” rather than “I want a banana. I want an apple”)

3rd Person Singular – learns to add an ‘s’ to the verb (action word) when it is followed by a 3rd person pronoun (he/she/it) – e.g. “He want**s** the ball”; “It eat**s** grass”; “She read**s** books”

Contracted Negative – learns to combine the auxiliary verbs (e.g. is, does, have, should) with the negative ‘not’ – (e.g. isn’t, doesn’t, haven’t, shouldn’t)

Contracted Copula – learns to combine a pronoun with a copula (i.e. a verb that connects the subject of the sentence to the word after the verb) – e.g. He**’s** happy

Past Participle –It’s brok**en**

Pronouns ‘his, hers, theirs’ – e.g. “It is **his/hers/theirs**”

Comparative –er and Superlative -est:e.g. big, bigg**er**, bigg**est**

Use of ‘is’ vs ‘are’ – learns to use ‘is’ and ‘are’ based on the number (i.e. ‘is’ for singular and ‘are’ for plural – e.g. “The monkey **is** eating a banana” vs “The monkeys **are** eating the bananas”)

Past Tense “to be” – e.g. “I **was** running” and “They **were** running”

Connector ‘because’ – learns to join two sentences together using the word ‘because’ – e.g. The boy was crying **because** he fell over and hurt his knee”

Adverb –ly – e.g. quick**ly**, slow**ly**, quiet**ly**

Irregular Plurals – irregular plurals are used fairly consistently by the age of 5 years (e.g. mice, children, men)

Irregular past tense – irregular past tense is used consistently (e.g. fell, broke, ate)

Direct Assistance for Language and Communication Skills

Instructions

Allen and Cowdery (2021b) provide a few direct teaching strategies and discuss milieu teaching. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Eileen K. Allen and Glynnis Edwards Cowdery in *The Exceptional Child: Inclusion in Early Childhood Education (9th).* 2021b

Many children with developmental disabilities require direct and specific assistance in order to develop language and communication skills. Direct assistance is used to augment—not replace—the rich and responsive communication environment of a quality inclusion program. Schwartz et al. (1993) offer a hierarchy of direct teaching strategies.

- *Choice-making*. The teacher presents two options and asks the child to make a choice.
- *Demand-model*. The teacher uses the focus of the child's interest (e.g., toy car) and demands a response from the child (e.g., "Tell me what you want"). If the child makes an incorrect response (e.g., "Boat!"), the teacher models the correct response (e.g., "Say car").
- *Topic continuation*. The teacher follows the child's conversational lead.
- *Time-delay*. The teacher looks expectantly at the child (for a request) before providing the desired material or activity.
- *Incidental teaching*. The teacher waits for a child to initiate and then responds immediately in such a way as to prompt a response from the child.

The degree of teacher assistance will vary according to the child's developmental needs and familiarity with the tasks. The child's relationship with the care provider and motivation are further considerations.

Milieu Teaching

This term refers to language-learning activities that go on throughout the day, across all activities, in the natural environment. Hepting and Goldstein (1996) offer a comprehensive review of naturalistic language intervention. Milieu teaching (Warren & Kaiser, 1988) incorporates the incidental teaching principles described in the research of Hart and Risley (1982). The child may be seeking information, assistance, materials, feedback, or reassurance. This means the adult can use a naturally occurring reinforcer such as the child's request for a material, information, or adult attention, to promote a brief but immediate learning episode. The teaching opportunity is a perfect match because the child is initiating the lesson based on an interest and a need. The more frequently a child contacts a teacher, the more opportunities

there are for the teacher to teach and for the child to learn. It is important, therefore, that each child make frequent contacts. To ensure such frequency, teachers need to be:

- readily available and eager to foster learning according to each child's skill level;
- interested in what the child is offering or inquiring about;
- prompt and positive in making a response, whether verbal, giving physical assistance, or giving additional materials and equipment;
- conscious of keeping the contact brief and focused on the child's expressed interest;
- sure the contacts are pleasant—even fun—for both the child and the teacher.

During a milieu teaching episode, the teacher never tells a child, "No, that's wrong," never criticizes, reprimands, drills, or lectures. The teacher's objective is to make the encounters so pleasant and rewarding that the child will return again and again for more teaching and more learning.

Emily, a four-year-old with a language disability, held a paint apron up to the teacher. The teacher knelt down, smiled, and waited, giving Emily time to make a request. Emily remained silent. After a moment the teacher said, "Emily, what do you need?" (The teacher did not anticipate Emily's need by putting the apron on for her.) When Emily did not answer, the teacher asked, "Emily, do you want help with your apron?" Emily nodded. "Tell me 'apron'," prompted the teacher. Emily made a sound somewhat similar to "apron," and the teacher said, "Yes, apron; that's right." When the teacher put the apron over Emily's head, she said, "Apron on," modeling what she would ask Emily to say once she had learned to imitate and could say the word apron.

Had Emily not said "apron," the teacher would have put the apron on and tied it anyway. The teacher also would have described the procedure in simple language. Never should a child be scolded, nagged, or coaxed. If teachers introduce pressure into spontaneous teaching opportunities, many children stop making the contacts. Some do without. Others turn to communicating their needs less appropriately through whining, crying, or sulking. Children who are most in need of the highly individualized help that makes milieu teaching so effective are usually the first to be put off at any sign of pressure.

Speech Irregularities

Instructions

While speech irregularities are very common in early childhood, children with special needs may have speech and communication issues because of their special need. Allen and Cowdery (2021e) discuss early warning signs and what early education professionals can do to support children as they learn and develop their speech skills. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Eileen K. Allen and Glynnis Edwards Cowdery in *The Exceptional Child: Inclusion in Early Childhood Education (9th).* 2021e

Irregularities, or dysfluencies, are typical of early speech development. Most children, 80 percent or more, will show some kind of dysfluency during the early years. For a time, the ability to formulate thoughts and ideas is greater than the child's ability to pronounce words correctly or to get them in the right order. The irregularities that early childhood teachers are most likely to encounter will be discussed briefly.

Many factors can affect the rate of language acquisition. For example, developmental disabilities can affect the production of language. The oral-structural differences associated with Down syndrome and clefts of the lips or palate can affect speech sounds. Cerebral palsy can affect both speech sound and production. Autism affects a child's ability to acquire both receptive and expressive speech.

Evidence has also been found that many children inherit their language disabilities. Spitz and Tallal (1997) found that children with a family history of language disabilities scored lower on receptive and expressive language tasks than those in a control group. At the same time, performance on a number of tasks that did not rely on language abilities did not differ as a function of family history. These results indicate that children with a positive family history for language disabilities are at risk for language disabilities.

Articulation Errors

Articulation refers to the production of speech sounds. Perfectly normal articulation errors are likely to occur as young children work at mastering the complex sounds that make up everyday speech. Misarticulations usually are classified as omissions, substitutions, additions, or distortions.

- Omissions. Sounds are left out, often at the beginning or end of words: "That's my agon (wagon)," "Here's the boom (broom)."
- Substitutions. Interchanging sounds such as b and v: "Put the balentines on the vack seat," or replacing one sound with another: wabbit for rabbit.
- Additions. Inserting sounds not part of a word: warsh (for wash) or Notta now (for Not now).
- Distortions. Deviations in speech sounds often occur because of tongue misplacement or missing teeth. Many six-year-olds with missing front teeth will say schwim for swim or tink for think.

Lisping

Rarely is lisping (pronouncing s as th) a worrisome concern in preschool children. Seldom does it persist. Exceptions may be those few cases where the child's lisp has been showcased by adults who think it is cute. If lisping should continue beyond the primary grades, parents are usually encouraged to seek consultation.

Dysfluency

Repetition of particular sounds or words, noticeable hesitations between words, extra sounds, or the undue prolonging of a sound are types of dysfluency. These kinds of speech irregularities are common, even typical. However, to label a young child as having a stutter is unwise, in part because the label may have a self-fulfilling effect. On the other hand, there are those few children who develop concerning dysfluencies during the preschool or primary school years. According to Zebrowski (1995), specific features of a common dysfluency such as stuttering distinguish it from a developmentally typical dysfluency. These include:

- frequency,
- type and proportion,
- duration,
- associated non-speech behaviors such as excessive frustration or grimacing.

These children should be referred to a speech and language pathologist for evaluation. Let it be emphasized: Teachers do not make referrals directly. However, when teachers are concerned about any developmental variation in a child, it is their responsibility to share their concerns with parents and to listen attentively to parents' responses and concerns.

Guidelines

A developmentally common speech irregularity seldom needs to turn into a major concern. Teachers and parents can help by practicing preventive measures.

How to Keep Common Speech Irregularities from Becoming Major Concerns

What Adults Should Do

- Make sure the child is getting good nutrition, adequate rest, and many more hours of active play than television viewing each day.
- Provide comfort, care, and support; reduce tensions as much as possible.
- Have fun with the child and with language; inject humor, simple rhyming activities, and songs into everyday routines.
- Discipline with calmness, firmness, and consistency; avoid harshness, ridicule, or teasing.
- Offer activities where the child can be successful and develop self-esteem.

What Adults Should Not Do

- Do not correct or nag the child; avoid saying, "Slow down," "Take it easy," "Think before you speak."
- Do not call attention to dysfluencies directly or indirectly; the child becomes all the more tense when an adult focuses with exaggerated patience, a forced smile, or a rigid body, waiting for the child to "get it out."
- Do not interrupt a child or act hurried; young children need plenty of time when trying to put their ideas into spoken language.

- Do not compare a child's speech unfavorably with another child's.
- Never attempt to change a child's handedness. (It is a myth that hand dominance and speech disorders are related.)

These suggestions are well summarized by what one group of speech and language specialists call benevolent neglect (Rieke, Lynch, & Soltman, 1977). Benevolent neglect is based on accepting common errors. To correct a child unnecessarily undermines the child's confidence. If children are to improve their language skills, they must keep talking. Children who fear they will be criticized each time they speak tend to speak less and less. Rieke and her colleagues offer adults an important rule: Never force a child to repeat anything that you have understood.

Referral

The importance of not overreacting to typical speech and language irregularities cannot be overemphasized (Berglund, Eriksson, & Johansson, 2001). On the other hand, if a disability exists, it needs to be identified as early as possible and an intervention program put into effect immediately. The early childhood teacher may be the first to suspect a disability. Whenever a teacher has concerns, parents should be counseled (and assisted, if need be) to seek help. Parents often have the feeling that something may be wrong. On the other hand, they can become so accustomed to their child's speech that they do not realize how atypical it actually is. Speech, language, and hearing clinicians who specialize in young children provide the most reliable testing and consultation for families at all income levels.

Early Warning Signs

Knowledge of typical development and skill in observing children helps teachers recognize signs of a possible disability. The Speech-Language-Hearing Division of Kansas University suggests that parents seek a professional evaluation if a child displays any of the following behaviors:

- Is not aware of sounds or noise.
- Is not talking by two years.
- Leaves off beginning consonants after three years.
- Uses markedly faulty sentence structure after five years.
- Uses mostly vowel sounds in speech.
- Is noticeably non-fluent after six years.
- Regularly uses a voice that is monotone, too loud, too soft, too high, or too low for the child's age and sex.
- Sounds as if he or she were talking through the nose or has a cold when none exists.
- Has frequent ear infections and signs of a possible disability.
- Is a year late in acquiring any speech and language skill.

Intervention

Children with speech and language disabilities need an individualized intervention program. For best results, the early childhood teacher and the therapist work together in designing, implementing, and evaluating the intervention. The speech therapist may work with the child

directly in the classroom or take the child out for short, individual sessions. It is becoming commonplace for the therapist to move with the child in the classroom, using the ongoing activities as the context for specialized instruction (Kaiser, Yoder, & Keetz, 1992).

Treatment may be largely ineffective unless therapy activities are coordinated with classroom and home activities. This allows practice throughout the day in situations that can be both fun and rewarding for the child. Therapists can promote home and classroom cooperation by informing teachers and parents regularly about the particular skills the therapist is working on and the progress the child is making. Therapists also can demonstrate specific strategies for the natural setting, where the usefulness of language is obvious to the child.

The foregoing does not imply that teachers (or parents) are expected to become language specialists. They can, however, readily learn simple procedures for facilitating individual children's speech and language development. A classroom application of a corrective strategy might be helping a child practice making the initial b sound. As a demonstration for the teacher, the therapist helps the child make the sound. The teacher and child practice several times in the presence of the therapist. The teacher then works with the child whenever an opportunity presents itself. The teacher uses milieu teaching strategies, and the child learns quickly because making the b sound always is related to something the child wants or is interested in. Example: "You want to play with the big ball. Tell me 'big ball.' "

English Language Learners (ELL)

Instructions

While a large number of English Language Learning (ELL) children end up in special education, this is not necessarily reflective of a disability. The education system still has some broken aspects and for some reason ELL children - also referred to Dual Language Learners (DLL) or Multi Language Learners (MLL) - are sometimes only able to get support within the special education system. For this reason, I am also including some information on supporting English language learners (ELL). Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Eileen K. Allen and Glynnis Edwards Cowdery in *The Exceptional Child: Inclusion in Early Childhood Education (9th).* 2021.

It is vitally important that teachers discriminate between disabilities and cultural or language differences. English language learners (ELL) are children whose first language is not English and who are in the process of learning English. The number of ELL students in the United States continues to increase, with an estimated 4.6 million students in the 2014–2015 school year. Spanish was the home language of the majority of these students, with Arabic, Chinese,

and Vietnamese being the next most common home languages (Ramirez, 2018). These rapidly increasing numbers of English language learners present challenges and opportunities for educators. Teachers must ensure that their students have access to the core curriculum while they are learning English language skills. The opportunity lies in the ability to strategically integrate language learning throughout the day.

The federal government requires districts to provide services to English learners, but it offers states no policies to follow in identifying, assessing, or instructing them. The President's Advisory Commission on Educational Excellence for Hispanics (initiated in 1990) expired in September 2017, and, as of 2020, there have been no new initiatives to improve education for English Language Learners in the United States. Due to this lack of policy, practices vary widely among the states.

It cannot be emphasized enough that everything in this chapter about facilitating language acquisition applies to helping children acquire a second language. Children learning a second language progress through the same language development stages and with the same predictability as any other child learning a language (Nilsen, 2010). To facilitate second language development, the first task of the teacher is to create a learning environment in which children have purposeful opportunities to use language, especially new language structures and vocabulary. The learning environment must focus on the importance of practicing language without fear of pressure or reprimand. In addition to multiple opportunities to use the new language (English), using their home language will also benefit children by allowing them to make connections between languages and demonstrating the value of their home language (Genesee, 2012). Teachers must plan an environment that gives English language learners plenty of reasons and opportunities to talk.

What Is the Most Effective Method for Improving ELL Achievement?

There is ongoing debate and discussion about which instructional method most effectively improves achievement for ELLs—bilingual education or English-only instruction. The following is a description of several different methods.

- English immersion. Instruction is entirely in English. Sometimes referred to as the sink-or-swim or submersion method of instruction, it can cause stress and feelings of being overwhelmed for the students.
- Structured English immersion (SEI). Students are taught entirely in English by teachers who have specialized skills in language instruction and possess a bilingual education or ESL/SEI teaching credential and/or training in specific strategies for second language instruction. In 1998, California successfully passed the Proposition 227 initiative, which mandated "Structured English-Immersion Instruction" for non-native speakers of English. Proposition 227 was based on some current educational research results that seemed to indicate that immigrant students who are non-native speakers of English perform much better in "mainstream" classroom settings after one or more years of "structured English-immersion instruction" than students who were subjected to traditional "bilingual education." Proposition 227 was repealed by Proposition 58 in California in 2016.

- English as a second language (sometimes referred to as Designated ELD). This approach addresses language learning as a separate curriculum and is often provided outside the mainstream classroom settings. Typically, classes are composed of students who speak many different languages but are not fluent in English. In this model, students are often taught in small groups according to their English proficiency and may receive some extra support in their native tongue. Classes may occur for only a period a day and focus strictly on English skills, not on content concepts (academics).
- English as a second language (sometimes referred to as Designated ELD). This approach addresses language learning as a separate curriculum and is often provided outside the mainstream classroom settings. Typically, classes are composed of students who speak many different languages but are not fluent in English. In this model, students are often taught in small groups according to their English proficiency and may receive some extra support in their native tongue. Classes may occur for only a period a day and focus strictly on English skills, not on content concepts (academics).
- Transitional bilingual education. The goal of this program is not biliteracy, but rather it is considered a pathway to English proficiency. Students remain in this program for a limited period of time (typically three to four years). Instruction for some subjects are in the students' native language (oral language, reading, and writing), but content or core curriculum is taught in English. A certain amount of each day is spent on developing English skills. Classes are made up of students who share the same native language in addition to students who only speak English.
- Two-way bilingual or dual-language education (sometimes also called dual-immersion). Classrooms are composed of students who speak two different languages. There is a promise of bilingualism, biliteracy, global awareness, and access to twenty-first-century skills (U.S. Department of Education, 2015). Instruction is delivered in two languages in all content areas. In this model, there is typically a pair of teachers with each one responsible to teach in only one of the languages. Students spend equal time with both teachers. This model requires a long-term commitment to reach the goal of biliteracy.

Slavin and Cheung (2005) analyzed research on the topic of bilingual education and reached a conclusion that favors bilingual education instead of English-immersion programs. They reviewed seventeen research studies and found that twelve showed positive results of bilingual education on a child's academic performance. None of the studies supported English-immersion programs, while five studies found no differences between English-immersion and bilingual education classes. While some research has concluded that bilingual education and English only methods work equally well to teach English literacy, authors in the journal The Future of Children (2011) report that "the quality of instruction is what matters most in educating English-learners."

Researchers Calderon, Slavin, and Madden (2011) list the individual components of effective models, which include integration of language, literacy, and academic content instruction, cooperative learning, professional development, parent and family support teams, and monitoring implementation and outcomes.

In April 2011, the White House released a report on improving Latino education. The following statement summarizes the current state of the education of English learners: “While there are certain practices that have been shown to benefit ELs, more research and evaluation are needed on the types of language-instruction programs that are most effective for English-learners” (White House, 2011).

Module 7: Facilitating Pre-Academic and Cognitive Learning

While some would argue that facilitating pre-academic and cognitive learning is the main focus of what schools do, in early education we sometimes forget that these are important topics as well. Especially play-based programs can sometimes lose site of the importance of building specific pre-academic and cognitive learning skills into the daily curriculum. This week we will look at how we can be sure we are supporting children with special needs in developing these skills, so they are ready for the transition to school.

Defining Pre-Academics

Instructions

Allen and Cowdery (2021a) define pre-academics and the importance of instructing the whole child, especially in early education. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Eileen K. Allen and Glynnis Edwards Cowdery in *The Exceptional Child: Inclusion in Early Childhood Education (9th).* 2021a

A growing number of preschool teachers and administrators have come to embrace the concept of pre-academics. They see it as more descriptive of the many types of learning activities that characterize the well-rounded preschool program and that are relevant to young children's ongoing learning experiences. Nevertheless, the issue of pre-academics is far from resolved.

A pre-academic curriculum includes the components that reinforce the concept of the whole child: physical activities, social interactions, and creative and affective development. Each area of development contributes to the child's cognitive learning.

"Identity crisis in the field of early childhood education" is the way Wolery and Brookfield-Norman (1988) refer to the differing viewpoints educators hold in regard to children's emerging literacy. They point out that terms such as preoperational and readiness are commonly used to describe the cognitive skills and abilities of children who are no longer infants but are not yet reading, writing, and doing arithmetic. These skills are pre-academic skills, necessary for young children to acquire during the preschool years if later they are to engage in formal academic activities.

Many parents, striving for what they perceive as best for their children, believe that early, formal instruction in reading, writing, and math will help their children succeed in school. Preschools

and childcare centers are pressured to demonstrate that children are doing more than playing, that they are learning “something worthwhile.” The pressure has led to many early childhood programs emphasizing paper-and-pencil tasks and workbook exercises. Such activities represent an inappropriate and ineffectual teaching format for the majority of young children. Drill-and-practice activities may actually reduce children’s natural curiosity, enthusiasm, and interest in learning (Parlakian, 2010). They also are contrary to the philosophy of this text and to the statement of Developmentally Appropriate Practices (NAEYC, 2020). However, a quality early childhood program cannot be all free play, it has to include a well thought out curriculum. As described in the DAP educators know how and when to choose teaching strategies to effectively promote each child’s development and learning at that moment. Such skills include the ability to adapt curriculum, activities, and materials to ensure full participation of all children. These strategies include but are not limited to acknowledging, encouraging, giving specific feedback, modeling, demonstrating, adding challenge, giving cues or other assistance, providing information, and giving directions (p.23). Blaustein (2005) expands on this position in the following statement:

A developmentally appropriate curriculum helps channel a child’s intrinsic motivation into learning activities through interactions and the child’s need to relate to others; through the use of imagination and the child’s need to wonder, question, and understand; and through integration and the child’s need to combine new knowledge with earlier experiences. Early childhood curricula that embrace these intrinsic motivations — the basic three I’s — (interaction, imagination, integration) and combine them with hands-on learning environments help children build a solid knowledge foundation (p. 3).

Supporting Young Children with Disabilities

Instructions

While this is a longer article than I usually like to include, it is quite comprehensive and talks about support in early elementary school - where our children are going next. Kebbeler and Spiker (2016) cover topics like language and social skills interventions, preschool curricula, instructional practices, and various systems of support. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Kathleen Kebbeler and Donna Spiker. 2016

Summary

What do we know about young children with delays and disabilities, and how can we help them succeed in prekindergarten through third grade?

To begin with, Kathleen Hebbeler and Donna Spiker write, identifying children with delays and disabilities to receive specialized services under the Individuals with Disabilities Education Act poses several challenges. First, even though eligibility is based on 14 disability categories listed in the law, each state determines its own criteria for those conditions. Second, young children—especially those with disabilities —are hard to assess. Third, deciding where to draw the line for eligibility along a continuum of functioning is a matter of policy rather than science. In recent decades, the authors note, the concept of disability has been moving away from a medical model that sees disability as an impairment that resides in the child and toward a framework that emphasizes children's functioning and interaction with their environments.

The authors review effective ways to support development and learning among young children with disabilities, including language and social skills interventions, preschool curricula, instructional and other practices, and multi-tiered systems of support. Then they examine a critical policy issue: the inclusion of young children with disabilities in regular education classrooms. One critical finding is that high-quality instruction in general education classrooms is a major factor in good educational outcomes for children with disabilities, and for their successful inclusion from preschool to third grade. Moreover, improving the quality of general education benefits all children, not just those with disabilities.

Hebbeler and Spiker also examine what we know about the transitions young children with disabilities make from one setting to another—for example, from prekindergarten to kindergarten. Here they conclude that we need far more research if we're to understand what makes such transitions successful.

Article

For nearly all children, the time between turning three and completing third grade involves adjusting to new environments. Some children go from preschool to kindergarten, and then on to first, second, and third grade. Others go to more than one preschool or child-care setting, or even change schools. Unfortunately, some young children in the United States still don't attend preschool at all, so their first major transition is from home to kindergarten. What happens in each of a child's environments, including the home, plays a critical role in what that child will know and be able do by the end of third grade. This is especially true for children with developmental challenges—delayed development, atypical development, or physical impairments that limit their ability to experience the world around them. These children require specialized support to achieve their full potential. It's well established that children who receive such support early in life are more likely to do well later.

This article focuses on children with delays and disabilities and the kinds of services and support these children need from preschool through third grade to experience good outcomes. We begin by discussing how young children with disabilities are identified, the challenges of identification, and a new framework for describing disability. We follow this with a summary of what is known about effective interventions to support development and learning in this population. The third section addresses a critical policy issue: the inclusion of young children with disabilities in regular education classrooms. The fourth section discusses what is known

about supporting children as they transition from one setting to another across the preschool to third grade span.

Identifying Children with Disabilities

Children Served Under the Individuals with Disabilities Education Act

Many US children with delays and disabilities receive specialized services under the Individuals with Disabilities Education Act (IDEA). This federal law was passed in 1975 and has been amended several times since. The 1986 amendments granted children aged three, four, and five the same rights the original law had given to school-age children with disabilities. These include the right to a free public education in the least restrictive environment appropriate to the child's needs. Each eligible child must have an Individualized Education Program (IEP). The IEP's required components include annual goals and a statement of the special education and related services the child will receive. To be eligible for special education, a child must have one of 14 disabilities identified in the law (see table 1), as well as an educational need that would benefit from special education.

In fall 2013, about 745,000 three- to five- year-old children, or 6.0 percent of US children in that age range, were receiving services under IDEA. By comparison, about 5.8 million children aged 6 through 21 were receiving IDEA services, representing 8.5 percent of that population. Among three- to five-year-olds, most were found eligible for special education services because of a primary disability of speech or language impairment, or a developmental delay. The next most common disability was autism. Among six- to nine-year-olds receiving IDEA services, the most frequent primary disability categories were speech or language impairment, specific learning disability, other health impairments, and autism.

These data conceal several challenges in identifying children for IDEA services. First, even though eligibility is based on the disability categories listed in the law, each state determines its own criteria for those conditions. For example, a state may use the developmental delay category with children older than five, but only 15 states do so through age nine. As a result of such differences, we see striking variation across states in the percentage of children who receive services. In 2013, the share of preschoolers receiving special education ranged from a low of 3.6 percent in Texas to a high of 10.7 percent in Arkansas. Among older children, the range runs from 6.2 percent in Hawaii to 11.5 percent in New Jersey.3 No evidence suggests that these differences result from differences in the nature of these states' populations. Rather, they are the result of policy choices.

Table 1

Disability Category	**Children 3-5** **Percent of Total**	**Children 6-9** **Percent of Total**

Speech or language impairment	44.2	40.7
Developmental delay	37.1	7.8
Autism	8.4	9.2
Other health impairment	3.0	10.2
Intellectual disability	1.9	4.4
Hearing impairment	1.2	1.2
Specific learning disability	1.2	20.2
Multiple disabilities	1.1	1.6
Orthopedic impairment	0.9	0.9
Emotional disturbance	0.4	3.1
Visual impairment	0.4	0.4
Traumatic brain injury	0.2	0.3
Deaf-blindness	Not available	

Source: Data from U.S. Department of Education, EDFacts Data Warehouse, IDEA Part B Child Count and Educational Environments Collection (2013-14). Data extracted as of July 3, 2014, from file specifications 002 and 089.

Young children—especially those with disabilities—are difficult to assess.

The second challenge in identifying children for IDEA services stems from the fact that young children—especially those with disabilities—are difficult to assess. However, assessment results are a major determinant of eligibility for IDEA services for children with the most common disabilities. State eligibility criteria are based on quantitative measures, such as the extent of a child's developmental delay, that are derived from assessment tools. The level of precision required for an eligibility decision far exceeds the capabilities of current assessment tools, which renders the process scientifically indefensible. Furthermore, many tools used to assess children aren't consistent with practices recommended by professional organizations.

The question of who gets served is further complicated by the fact that disability and delay lie at one end of a continuum of functioning. Most of the continuum is considered typical development. At some point along that continuum, functioning falls so far below what's expected for a given age that a child's development is considered to be delayed or atypical. Deciding where to draw that line for eligibility purposes is a matter of policy, not science. The language skills of a child who scores slightly above the eligibility criteria differ very little from the skills of a child who scores slightly below them. Both children would likely benefit from intervention. But resources are limited, so the states must set criteria to determine who will and will not be served. The question is whether the criteria, as well as the way identification procedures are carried out, should be more equitable from state to state.

Identifying a learning disability by using the gap between a student's ability (as measured by an IQ test) and his or her achievement levels has been widely criticized as atheoretical, inconsistent, unfair, and costly. Dissatisfied with that discrepancy model, many school districts have adopted a model called multi-tiered systems of support (MTSS), in which intervention becomes more intense as students move through tiers of instruction. Students who don't make progress with high-quality instruction in a general education setting (tier 1) receive more intensive evidence- based interventions, either in small groups (tier 2) or individualized (tier 3). MTSS models rely on regularly monitoring student progress and using data to decide which students need additional support and special education. Such models, which have been used to identify and support students with learning disabilities and behavior problems, represent a promising approach for determining eligibility for special education among some subgroups of children with disabilities. We'll return to MTSS when we discuss interventions.

Interestingly, the number of children with different disabilities changes as children get older, as some are newly identified, and others are considered to no longer have a disability. In fact, the proportion of children with different disabilities served under IDEA varies from one age to the next. The number of children receiving special education increases for each year of age between three and nine. In 2013, almost three times as many nine-year-olds as three-year-olds received special education (487,000 vs.173,000).6 Much of the increase occurs as more students are identified with learning disabilities across the early grades. The number begins to climb at age six and rises each year, as figure 1 shows. By contrast, the number of children with speech or language impairment peaks at age six and then decreases each year; at age nine it's surpassed by the number of children with learning disabilities. Finally, the number of children identified as having developmental delays drops continuously between ages four and nine. However, some of this decline occurs because most states don't use developmental delay as an eligibility category for six- to nine-year-olds.

We could speculate that some children who are classified with speech and language delays in preschool are simply reclassified as having a learning disability in elementary school. A longitudinal descriptive study that followed children who received special education from preschool onward found that about 16 percent left special education each year. According to that study, the year- to-year decline in speech and language impairments reflects the fact that these children are no longer receiving special education. A critical question is whether children who are identified as having a learning disability when they experience academic difficulty in early elementary school could have been identified and served earlier.

ICF-CY: A New Approach

The identification of children for IDEA services follows a medical model that identifies and describes disability based on categories, such as deafness or intellectual disability. The categorical approach sees disability as a condition that resides in the child. It also masks the extreme variation within each category. Although disability lies at one end of a continuum of human functioning, we see large differences among children with the same diagnosis. These differences have significant implications for identification, service delivery, and research. Children with the same diagnosis can differ in many ways, for example in the severity of delays

and functioning levels, rates of skill acquisition, health status and conditions, social and behavioral characteristics, and, ultimately, developmental and educational outcomes.

Over the past few decades, the concept of disability has moved away from a medical model and toward a framework that emphasizes an individual's functioning and interaction with the environment, rather than impairment. The new approach adopts a social model of disability, recognizing that society—through policies and environmental adaptations—either facilitates or impedes the way individuals participate in daily activities. This framework is reflected in the World Health Organization's International Classification of Functioning, Disability and Health—Children and Youth (ICF-CY), a taxonomy for classifying functioning that focuses on the way health conditions interact with personal and environmental factors. The ICF-CY overcomes many of the medical model's shortcomings by characterizing functioning along multiple dimensions. It also captures the extent to which a child's environment supports participation in daily activities. In this framework, disability doesn't reside in the child; rather, it's a function of the child and the child's environment.

Consider, for example, the experiences of two children who communicate by signing. One attends a child-care center where the caregivers sign; the other attends a center where they don't. Caregivers who sign provide the first child with the same learning and communication opportunities that spoken language provides to children who hear. The second child experiences a world with far fewer learning opportunities because no one can communicate with her. Or consider the contrasting experiences of two children who use wheelchairs. One lives in a single-story house with easy access to a backyard. The other lives in a second-floor apartment of a building with no elevator. Although these children may have exactly the same degree of hearing loss or motor impairment, their environments offer very different levels of access to learning opportunities.

Viewing disability in this way means examining the extent to which a child can or cannot participate with family members and peers in day-to-day activities at home, at preschool, and in the early primary grades. Environments that aren't adapted to meet children's level of functioning restrict their participation in everyday activities, thus impairing their ability to develop and learn. Missing opportunities to learn is especially harmful for young children because it limits their future ability to fully participate in everyday activities. For children with disabilities, a critical environmental factor that heavily influences their future participation is access to the specialized services they need to promote development and learning in their preschool years so they can succeed in elementary school.

Many aspects of the environments children experience are determined by policy choices.

The ICF-CY's emphasis on the role played by environment in childhood disability has significant policy implications related to prevention and intervention. Many aspects of the environments children experience are determined by policy choices. A horrific example of the relationship between policy and disability is the severe cognitive and social delays experienced by children placed in Romanian orphanages. These children, who spent their early years in extremely deprived conditions, suffered permanent damage to their functioning as a result. In the United States, risk factors such as lack of prenatal care, environmental toxins, and toxic stress

contribute to developmental problems. On the other hand, wheelchair ramps, assistive technology, and effective educational and therapy services are positive environmental features that can reduce the extent to which a limitation of body structure or function impairs a child's ability to develop and learn. The special education services provided under IDEA are a powerful example of a policy that has positively altered the day-to-day environments of children with disabilities. However, implementation challenges still exist, such as providing consistent access to quality services, securing sufficient funding, and achieving good outcomes for all recipients.

We don't know how many US children would be identified with a disability using the ICF-CY or another more functional approach. One study, the 2005 Survey of Income and Program Participation, combined a medical and functional approach, defining disability for three- to five-year-olds in three ways: as developmental delay; as difficulty walking, running, or playing; or as difficulty moving arms or legs. The study found that, according to parents' reports, these characteristics applied to 3.8 percent of the population. For six- to 12-year-olds, the definition was expanded to include more categories (for example, autism and cerebral palsy), producing an estimate of 12.8 percent for this age group. In 2008–09, the National Health Interview Survey asked parents about both limitations (such as whether their children needed help bathing or showering) and diagnostic categories, yielding an estimate that 4.7 percent of children under six and 9.5 percent of children aged six to 11 had disabilities.

In addition to its implications for identifying children with disabilities and delivering services to them, the ICF-CY can also help guide research on the development and learning of children with disabilities. Research based on categorical designations (such as cerebral palsy, spina bifida, or learning disability) is likely to continue, but researchers also need to describe children's functioning across multiple dimensions to more clearly communicate which children are covered by the findings. Intervention researchers in particular need richer descriptions of their subject —using a perspective derived from ICF-CY—to make their findings easier to generalize to a broader population and translate into practice.

Effective Interventions

The field of research into how effectively interventions support the learning and development of young children with disabilities goes back 60 years. In fact, many of today's interventions have their roots in model demonstration projects funded in the 1960s. Although our knowledge about which practices are effective continues to grow, much remains to be done. Given the diverse needs of children with disabilities, it's not surprising that many studies have found that specific interventions or services can achieve specific outcomes for specific subgroups of children. For example, physical therapy can help children with motor delays, while applied behavior analysis can help children with autism. But we don't know whether some of these practices can be effective for other outcomes or other subgroups.

It's difficult to conduct research on the effectiveness of various interventions for children with disabilities. One challenge is the fact that all children are entitled by law to individually determined services, which eliminates the possibility of random assignment and the creation of a control group that receives no treatment. Other challenges include the extreme heterogeneity of the population, even among children categorized as having the same disability; assessment

tools that haven't been validated for use with children with disabilities; and the recruitment of sufficiently large samples for studies of low-incidence disabilities.

Even studies with random assignment that use a treatment-as-usual control group are logistically difficult to fully implement, because knowledgeable parents often seek potentially beneficial treatments, and researchers can't control this. To tackle some of these challenges, research in special education often uses single-case designs to examine how interventions affect children's learning and behaviors. These single-case designs have been widely used with applied behavior analysis (which we describe later). They provide strong evidence when comparable results are found across children in one single-case study or from multiple single-case studies of an intervention with different types of children or in different settings. It wouldn't be possible for this article to cover the entire body of knowledge on effective practices and programs for children with disabilities. Instead, we've elected to highlight several research areas to illustrate the types of studies conducted by researchers on promoting positive social and academic outcomes for children with disabilities in preschool and the early elementary grades.

Foundational Role of Applied Behavior Analysis

From the 1960s to the 1980s, many studies examined whether behavior modification or stimulus-response approaches, also known as applied behavior analysis (ABA), could affect specific behaviors displayed by children with disabilities. Studies have shown that ABA techniques, which use reinforcement principles and stimulus-response models of learning, can help establish desired behaviors as well as consolidate and generalize them. Most ABA studies have been highly controlled investigations of specific practices, rather than evaluations of a type of service or a program, often using rigorous single-case designs.

Early studies focused on discrete behaviors because, at the time, most researchers believed that children with disabilities couldn't learn many of the skills that typically developing children master, such as reading. Further research showed this belief to be wrong. Those early ABA studies examined atypical behaviors that interfered with children's ability to learn typical skills—for example, self-stimulation behaviors or lack of interest in others. But other researchers and practitioners criticized the interventions for focusing on isolated skills that didn't generalize to everyday situations or weren't particularly useful for helping children function in everyday settings.

As a result of this criticism—and consistent with the functional views of disability that we described earlier— more recent ABA research has focused on teaching meaningful behaviors. For example, a method called pivotal response training emphasizes a child's motivation to learn by explicitly teaching attention and self-regulation behaviors that help them "learn to learn." These behaviors include initiating and maintaining social interactions, attending to the same thing at the same time with another person (for example, looking at a toy together), and responding to multiple cues. Many ABA studies focus on a single type of disability, most commonly autism or intellectual disability, although some focus on a specific curriculum. The next sections highlight how ABA practices, along with research on child development, underlie much of the research on interventions for young children with disabilities.

Language and Social Skills Interventions

Many young children with disabilities struggle with language and communication. Poor language development is especially problematic because language skills are the foundation for learning to read and for successful interactions with peers. Researchers examining practices and strategies to promote communication skills have focused on teaching children sounds, words, and so on, often using ABA methods. Interventions have emphasized improving the quantity and quality of language input based on what we know about language development in typical children. Practices that support highly responsive and functional conversations in natural contexts, with both peers and adults, have been shown to promote children's communication and cognitive skills. Many studies have been conducted on these practices; some have had single-case designs but randomized controlled trials (RCTs) have been limited.

Poor language development is especially problematic because language skills are the foundation for learning to read and for successful interactions with peers.

Likewise, children with disabilities often have trouble interacting competently with peers and adults—the important social partners from whom they learn skills and with whom they must connect to fully participate in everyday settings. Social skills training uses behavioral approaches to teach children age-appropriate social competencies such as communication, problem-solving, decision-making, self- management, and relating to peers. A review of 23 studies involving three- to five- year-olds with disabilities showed that social skills interventions can increase positive social interactions and reduce problem behaviors. This review included studies with multiple- and single-group designs, some of which used quasi-experimental methods, but none were RCTs.

Social skills training can take place in both regular and special education classrooms, and a variety of approaches have been developed. For example, teachers may use a structured approach to explain to students how to perform a desired behavior, giving examples and reinforcing targeted behaviors through questions, answers, and other feedback. In a more nuanced approach, often referred to as incidental teaching, teachers respond to students' own utterances, interactions, and behaviors to encourage the desired social skills (for example, by rewarding positive play).

Limited but promising research backs peer-directed interventions, which use peers in natural settings as the primary interventionists to promote social communication in children with disabilities. Typically developing peers who have learned strategies to promote social communication interactions are paired with children with disabilities during play. In some interventions, peers learn strategies to increase interactions, engagement, and communication (such as making requests, paying attention to others, and taking turns).

Preschool Curricula

Few curricula have been developed specifically for young children with disabilities. One curriculum with evidence of effectiveness from an RCT is Teaching Early Language and Literacy (TELL). This approach involves a set of instructional sequences, scripted teaching activities,

and materials for activities to build oral language and early literacy. The Incredible Years curriculum—which focuses on acquiring social skills and reducing behavior problems, positive parenting, and improved classroom management for students in preschool through early elementary school—has a strong research base, including RCTs. The Incredible Years training programs for children, parents, and teachers can be used independently or in combination. Supported by professional development materials to train teachers, therapists, and parents, Incredible Years has been used successfully in classrooms, clinical settings, and parent groups.

Interestingly, preschool curricula created for typically developing children have not been well studied to see whether they're effective for children with disabilities. Because so many children with disabilities attend regular preschools, this is an important area for future research.

Instructional Practices

What constitutes high-quality instruction for children with disabilities? Research has identified a number of components. During the preschool years, one important goal is to promote early literacy—oral language, phonological awareness, print awareness, and letter knowledge. These skills are the foundation for later instruction in formal literacy and reading. Practices that support early literacy for typically developing children apply equally well to young children with disabilities—reading books, for example, and teacher-child interactions that focus on asking questions and making predictions to facilitate language development.

However, for children with disabilities to generalize the skills they learn and maintain them over time, they often need instructional practices that are more intense or longer in duration than those that work for typically developing children. Unfortunately, researchers have mainly examined children who receive language and communication interventions delivered by specialists, either in clinics or in small groups within classrooms. We need to know whether teachers can feasibly and effectively implement these same interventions in classroom settings. We also need more research about the appropriate balance between child-directed and teacher-directed activities—that is, activities in which teachers impart specific literacy skills that children then practice with their peers in play and during other developmentally appropriate classroom activities throughout the day.

We also have good evidence of effectiveness for naturalistic instruction, in which teachers use naturally occurring settings and activities as the context for teaching interactions. We've seen that this approach can help children learn new social, language, motor, self-help, and pre-academic skills, but no studies have used RCTs. An example is embedded instruction—an activity-based intervention that occurs during everyday activities such as play or routines such as feeding, bathing, or dressing. Adults deliberately arrange the environment and materials to support a child's development and elaborate on child- initiated behaviors to build a child's skills.

Practices Recommended by the Division for Early Childhood

To support the use of evidence-based practices in the field, the Division for Early Childhood of the Council for Exceptional Children—an international organization for those working with and on behalf of young children with disabilities—has identified 66 recommended practices for

people who work with young children with disabilities and their families. These practices reflect the best available empirical evidence as well as the consensus of professionals in the field in eight areas—seven for practitioners and one for program leaders.

For practitioners, the recommendations cover assessment, environment, families, instruction, interaction, collaboration, and teaming (regular communication and interactions among practitioners from multiple disciplines). The practices encompass the most effective ways to improve learning outcomes and promote the development of young children (aged zero to five) who have or are at risk for delays and disabilities. The recommendations build on developmentally appropriate practices that are recognized within the early childhood special education community as necessary but not sufficient for children who are experiencing developmental challenges. These recommended practices are not specific to a particular disability and can be delivered in all settings, including general early childhood programs.

Multi-Tiered Systems of Support

As we've said, over the past decade school systems have been moving toward multi- tiered systems of support for children who face learning and behavioral challenges, including children with disabilities. MTSS, also known as response to intervention, has no single definition, but most descriptions share the components we described earlier: tiers of instruction, with intervention becoming more intense as students move up the tiers; high-quality instruction in general education settings; continuous measurement of students' learning and progress; a set of data-based decision rules to identify which students need intervention, and at which level; individualized evidence-based interventions; and consideration of special education services for students who don't make sufficient progress.

The Division for Early Childhood, the National Association for the Education of Young Children, and the National Head Start Association have jointly described the four core features of a response to intervention approach in early childhood as: multi-tiered systems of teaching and caregiving practices; a high-quality curriculum; ongoing assessment and monitoring; and collaborative problem- solving among team members.

The MTSS approach recognizes that poor teaching can contribute to a child's learning problems.

At each tier, evidence-based approaches are central to effectiveness. For example, Tier 1 in an MTSS approach—the general education classroom—uses evidence-based curricula that give all children the chance to succeed with good instruction. When monitoring shows that children aren't succeeding, tier 2 methods are brought in, such as more frequent or longer instruction, learning in smaller groups, or instructors with more specialized expertise. The MTSS approach recognizes that poor teaching can contribute to a child's learning problems; its emphasis on high-quality instruction in the general education classroom as part of an identification framework is consistent with the functional approach to disability. Some researchers believe that the MTSS approach may ultimately influence how many children are identified for IDEA services, and may also change the nature, placement, intensity, and timing of the services they receive.

Emerging evidence shows that the MTSS approach improves academic and behavioral outcomes. But we need more research, especially about how districts are implementing MTSS. Some studies show that in kindergarten through third grade, interventions with a multi-tiered framework can help struggling readers improve. Other studies—of entire school districts that have successfully implemented MTSS models report improved academic achievement in reading, math, and language arts. However, a more recent national study that used a regression discontinuity design—a research design that takes advantage of the fact that students who fall just below the cutoff score on a screening test receive services, while those just above the cutoff don't—failed to show positive impacts on reading in the early elementary grades.

One MTSS model with strong evidence of effectiveness, including evidence from RCTs, is called Positive Behavioral Interventions and Supports (PBIS). Designed for kindergarten through 12th grade, PBIS uses school-wide problem- solving models to discourage inappropriate behavior by teaching and reinforcing appropriate behaviors. PBIS has been shown to reduce behavior problems, improve social skills, and improve the school climate—that is, the subjective experience of a school that includes norms, values, and expectations that help children and adults feel socially, emotionally, and physically safe. Taken together, these factors allow for more and better opportunities for high-quality academic instruction. With PBIS, a range of interventions are systematically applied based on the students' demonstrated level of need. The program explicitly addresses the environment's role in the development and improvement of social and behavior problems. PBIS is also being combined with school-wide literacy interventions; recent research on PBIS is focusing on how to sustain school-wide positive behavioral interventions and supports.

Early childhood programs, too, are increasingly using multi-tiered approaches. The expansion of MTSS among younger children isn't driven by the desire to better identify students with learning disabilities, as it is with the school-age population. Rather, multi-tiered models are promoted as a way to meet preschool children's diverse needs, especially given the current emphasis on including young children with disabilities in regular early childhood programs (a topic we discuss in the next section).

One MTSS approach for early childhood is called the Pyramid Model. A collection of evidence-based practices to increase social- emotional skills and decrease challenging behaviors in preschool classrooms, it uses three tiers of increasingly intensive interventions. The practices were identified by systematically reviewing the research on prevention and intervention practices that led to positive social- emotional outcomes and fewer challenging behaviors in young children, both with and without disabilities. In the community preschool programs where it has been implemented, the model has been found to increase children's pro-social behaviors and to reduce behavior problems in a study that used a single-case design.

Research has also shown that teachers can be coached to implement the Pyramid Model with fidelity. The model's developers have reported positive social and behavioral outcomes in children from one RCT, but they admit that more RCTs are needed. They also acknowledge that we should learn more about the types of professional development and other factors that can help to effectively implement and sustain the model.

In general, although multi-tiered models have shown positive effects, we need more research to guide their implementation in early childhood. Indeed, all the features of MTSS in early childhood need more study. For example, what are the best approaches for universal screening and for monitoring progress? Which decision-making models best identify the children most likely to benefit from more-intensive interventions? And how should we set the hierarchy of more-intensive and supplemental instructional techniques for children who don't make good progress with the less- intensive approaches?

Including Children with Disabilities

The drive to educate children with disabilities alongside typically developing children has been one of the most remarkable changes in preschool programs and the early elementary grades over the past several decades. This progress has been achieved by parent advocacy and the legislative requirement that children with disabilities must be educated in the least restrictive environment. Opening the doors of general education classrooms gives children with disabilities access to the general early childhood or elementary curriculum, typical peers, and more of the typical activities available to other children. The practice thus holds a promise of better academic and social outcomes. Inclusion, by focusing on full participation and the necessary supports to allow that participation, is also consistent with the ICF view of disability.

In 2013, however, despite IDEA's longstanding mandate for placement in the least restrictive environment, more than one-third of preschool children with disabilities (34.2 percent) spent no time in a general early childhood program. Instead, they received their special education services in a separate class or other setting. Recently, the US Department of Education and the Department of Health and Human Services released a set of recommendations reaffirming the importance of including young children with disabilities in high- quality early childhood programs alongside their typically developing peers.

Inclusion is more than placement. It must give young children with disabilities a sense of belonging and membership, and access to positive social relationships— as well as development and learning.

But inclusion is more than that. A joint position statement from the Division for Early Childhood and the National Association for the Education of Young Children defines three components of inclusion: access—that is, a wide range of typical environments and the use of universal design to support full access; participation, including methods that support and promote children's full participation, such as embedded instructional approaches; and supports— infrastructure to support staff, such as appropriate professional-development opportunities and specialized services in the setting. According to that position statement, inclusion is more than placement. It must give young children with disabilities a sense of belonging and membership, and access to positive social relationships—as well as development and learning.

Beginning in the 1980s, experimental preschool programs demonstrated that children with disabilities could learn alongside typically developing peers while both groups made good progress. That finding has since been replicated in many other studies. A review of 22 studies conducted by the 1990s found that preschool-age children with disabilities who are served in

inclusive rather than segregated settings have better outcomes on standard measures of development, social competence, play behavior, and engagement. Of the 22 studies reviewed, 18 used group designs but only six used RCTs.

A more recent research synthesis concluded that children in inclusive classrooms need specialized instruction to achieve good child outcomes. It also found that families of children with disabilities generally view inclusion favorably, although some of them worry about the quality of early childhood programs and services; that early childhood professionals may not be adequately prepared to serve young children with disabilities enrolled in inclusive programs; and that a variety of factors—such as policies, resources, and beliefs—influence whether inclusion is accepted and how well it's implemented.

We know little about what happens to children with disabilities who have experienced inclusive programming in preschool after they enter kindergarten. One small study that began following such children in kindergarten found that after five years, only 60 percent of them remained in some form of inclusive placement. Another study found that a significant number of children with mild developmental delays who had been fully included in preschool and kindergarten were not in an inclusive placement by first and second grade.

Many factors influence the success of inclusion in the early grades. Are paraprofessionals or aides available to work with the child? Does the child's family advocate for inclusive placement? Do the teachers have the appropriate knowledge and attitude about serving children with disabilities? Moreover, at the elementary level, it's easier and more common to include children with milder disabilities in general education classrooms than children with more significant disabilities.52 Clearly, we need more research on promoting successful inclusion. Because principals play an important role in supporting inclusive programming in elementary schools, training in special education should be part of their higher education preparation and professional development.

Making Transitions

For young children with disabilities and their families, transitions can be challenging. If a child's disabilities are identified before age three, the family will face moving the child from an infant-toddler program to a preschool program. The shift from mainly home-based services to a group preschool setting will require the child to have certain social, behavioral, and communication skills to meet the demands of the new setting. For many families the transition occurs relatively quickly, as children are often identified for early intervention (services from birth to age three) only after 15 months of age. For children who receive special education services in preschool, the next transition is to kindergarten, with an accompanying shift to higher academic expectations. Interestingly, IDEA regulations have requirements that cover the transition from early intervention to preschool, but none covering the transition to kindergarten.

That transition is widely recognized as amajor life experience for young children. In response, schools have increasingly implemented practices to support successful transition. A national study of preschool special education recipients found that on average kindergarten teachers used 5.4 different transition practices. The same study showed that special education teachers

provided more support than regular education teachers. More than 80 percent of kindergarten teachers reported that they received children's records and other information from the children's preschool programs, and that their schools encouraged parents and guardians to meet the child's new teachers. Smaller districts, wealthier districts, and suburban and rural districts offered more support than larger, poorer, and urban districts. Parents and teachers alike reported that when the school took steps to facilitate the transition, the process was easier for children. Overall, 16 percent of parents said that the transition to kindergarten was somewhat or very hard for their child. But that figure was as high as 51 percent for children whose primary disability was emotional disturbance.

We need far more research on the factors that lead to successful transitions for young children with disabilities. We also need to refine the definition of what constitutes a successful transition. Until now, research has focused on the transition from preschool to kindergarten, and mostly looked at transitions for typically developing children. Young children with disabilities don't just make major life transitions, going from early intervention to preschool and from preschool to kindergarten. Many also make smaller transitions daily or several times a week—for example, when they go from a preschool in the morning to a child-care home in the afternoon. This complexity has led to calls for more research about the best ways to smooth these transitions and improve transition policies and practices. Support for transitions is another example of how environmental factors can mitigate the impact of a child's developmental challenges.

Conclusions

Recent developments—such as the renewed emphasis on inclusion and multi-tiered support systems to provide specialized intervention to all children who are struggling—are blurring the distinction between regular and special education High-quality instruction in general education classrooms, the first tier in an MTSS, is a major factor in good educational outcomes for children with disabilities, and for their successful inclusion from preschool to third grade. Efforts to improve the quality of general education, such as statewide quality rating and improvement systems and various K–3 educational reform initiatives, will benefit all children, including those with disabilities. Creating environments that support social development and help children learn new skills both remediates and prevents learning and behavior problems.

Providing high-quality learning environments is consistent with the newer concept of disability, which emphasizes functioning and sees disability as the interaction between the individual and the environment. Educational environments from preschool to third grade aren't neutral factors when it comes to existing and emerging disabilities. These environments contribute positively or negatively to the way children will function—and even, for some children, to whether they are considered disabled at all.

The past 50 years have seen substantial research on effective instruction and interventions for young children with disabilities. We still have much to learn, of course, especially with regard to what works best, and for whom. We need to ensure that preschools and classrooms around the country use evidence-based practices. Implementation science provides a framework for improving the quality of tier 1 environments, and also for increasing the frequency and fidelity with which evidence-based practices are implemented.

We also need comprehensive approaches to professional development that are coordinated with the general education community. More effective general education and special education teachers will allow children with disabilities to receive the individualized services that IDEA requires and will benefit all children. New models of teacher training, both preservice and professional development, will require more collaboration across general and special education, as well as supportive leadership. If all children are to reap the benefits of effective teaching, professional development needs to be seen as an essential feature of schools' organizational systems. Professional development must support such innovative approaches as co-teaching, coaching, consultation models, professional learning communities, and communities of practice. It must also encourage new ways of teaching, of classroom staffing, and of classroom organization.

Finally, teachers and other staff need support in their efforts to truly individualize instruction for all children, including those with disabilities and learning or behavioral challenges. Appropriate education for children with disabilities is not just an issue of where they are, but also of what is happening to them. Effective educational practices from preschool through third grade are essential to the full participation of children with disabilities—now and in the future.

Module 8: Managing Challenging Behaviors

The topic of challenging behaviors comes up in all of my courses - it is the topic that I get the most questions about. We do have a class, CHDV C111 Principles of Child Guidance, that looks specifically at managing challenging behaviors and is very useful to take as a parent and as an early educator. What is interesting about the course is the focus is mostly on communicating effectively. Behavior is a form of communicating and children who are still learning to communicate will have more frustration and upset due to the lack of being able to communicate effectively. Children with special needs may not be able to or may be delayed in developing their ability to communicate effectively verbally which can cause even more frustration and upset. Before condemning a child or behavior, we have to first look at what the child and behavior are trying to communicate so we can assist the child in meeting his/her needs.

Screening for Disruptive Behaviour Problems in Preschool Children in Primary Health Care Settings

Instructions

While this resource is more for pediatricians and the medical field, it has important information that could be useful in preschool programs - and it is always useful to see what doctors are doing. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Alice Charach, Stacey Ageranioti Belanger, John D. McLennan, and Mary Kay Nixon. 2017

Background

Disruptive behaviour problems, such as severe temper tantrums, aggression and pervasive noncompliance, affect an estimated 9% to 15% of preschool-aged children. In addition to having adverse impacts on current child function and increasing family stress, these behaviours represent risk factors for, and/or potential components of, a range of neurodevelopmental and mental health disorders. Examples of associated disorders include attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder, anxiety and mood disorders, as well as cognitive and language disabilities. For a significant proportion of preschool children, both clinical and subclinical levels of disruptive behaviours can persist into the early primary school years, placing children at risk for poorer academic, physical and mental health outcomes into adolescence and adulthood. Quality of life for children with disruptive disorders—and their families—is lower, while the costs to society for academic, social support, health care and criminal justice services are higher than for typically developing children.

One Canadian study suggested that 25% to 30% of children are not developmentally ready for school when they arrive in junior kindergarten. Gaps in behavioural and emotional self-regulation can interfere with a child's ability to participate successfully when they enter school. In this age group, such gaps can present as disruptive behaviours and, if identified early, may benefit from intervention.

Identifying Disruptive Behaviours

Children's social, emotional and behavioural functioning can vary substantially between 2 to 5 years of age, based on their developmental level and specific environmental and caregiver contexts. The frequency of aggression and temper tantrums typically peaks around 3 years of age and, for many children, represents a transient developmental stage rather than a clinically significant problem. Behaviours that are considered normative at age three may indicate a clinically significant problem or disorder at age five. Most children gain control over aggressive impulses and develop prosocial skills in response to the structures and expectations set by their parents and care providers, as well as by simply maturing. Associated difficulties may matter. For example, one study found that preschool children with ODD alone were unlikely to have a diagnosed disorder at age eight compared with children whose ODD co-occurred with an anxiety or mood disorder or with ADHD.

A key unresolved challenge is how to distinguish those children with disruptive disorders who are likely to benefit from early identification, evaluation and intervention from those whose disruptive behaviours will probably follow a normal developmental trajectory with little or no intervention. However, recognizing problematic disruptive behaviours involves more than assessing whether or not a difficulty will resolve on its own. Clinicians must also identify situations in which a child's behaviour is causing significant distress or interfering with normal adaptive child and family function.

One approach to these complex issues is to consider patterns across domains or dimensions of disruptive behaviour: noncompliance, aggression and temper loss. While it can be challenging to distinguish developmentally normative from atypical behaviours in preschool children, particularly when considering temper loss and noncompliance, there are some cases where frequency, intensity and duration flag the child's behaviour as atypical. Such behaviours occur in less than 5% of community paediatric populations and can be considered as potential indicators of a problem or as 'red flags' requiring evaluation or monitoring. Some examples are outlined in Table 1. A cluster of disruptive behaviours is considered to be at the disorder level when the following criteria are met:

- Behaviours are atypical for the child's developmental age and persist for 6 months or more,
- Behaviours occur across situations, and result in impaired functioning, and/or
- Behaviours cause significant distress for both child and family.

Dimension	Normative misbehaviour	Problem indicator

Noncompliance	Says ‘no’ when told to do something	Misbehaves in ways that are dangerous (e.g., refuses to hold a parent’s hand and instead runs into the street)
Aggression	Acts aggressively when frustrated, angry or upset	Acts aggressively to try to get something he or she wants
Temper loss	Loses temper or has a tantrum when tired, hungry or sick	Has daily temper tantrums; has tantrums that last >5 minutes*

*There is no consensus regarding the threshold at which a child’s tantrums shift from being normative to atypical. However, factors considered during assessment include frequency (e.g., daily or in repeated clusters), intensity (e.g., with aggressive behaviours, such as hitting, biting or kicking) and duration (e.g., >5 minutes per bout).

ASSESSMENT FRAMEWORK AND DIFFERENTIAL DIAGNOSIS

Disruptive behaviours in preschool children involve complex child–environment interactions. Broadly speaking, a bioecological framework examines the young child within his or her family and community contexts. The practitioner should review, systematically, the individual child, the family and environmental domains. This bioecological framework can also be used to complete a mental health assessment and develop a management plan.

At the child level, inquire about the pattern and persistence of disruptive symptoms and their triggers, especially noting what makes problem behaviours worse or better. Table 2 lists the domains that require assessment. Evaluating the child’s adaptive functioning across settings will clarify pervasiveness and severity of impairment. It is also important to note protective factors—child and family strengths—such as cognition, stable employment or a supportive family network.

Child	Family	Environment
Cognitive levels	Parent*–child interactions	Support from family and quality of social network
Language and communication (e.g., delays and atypical patterns)	Prolonged separation from a parent*	Quality of child care or alternate care arrangements
Social skills	Parental* medical or mental health	Neighbourhood characteristics
Emotional regulation (e.g., excessive fears or angry outbursts)	A parent’s* employment status	Household composition

Attention, overactivity and impulse regulation	Housing or food insecurity
Eating and sleeping patterns	Presence of domestic violence
Adaptive functioning	Presence of child abuse or neglect
	Parenting practices

*Mother, father or alternative main caregiver.

There are a few specific health conditions that can contribute to disruptive behaviours. As a general rule, the child should have been screened for hearing and vision impairments as well as for irregularities in feeding and sleeping. Excessive impulsivity, hyperactivity and inattention may signal early ADHD. Language and social communication delays may be associated with a primary language or communication disorder or with autism spectrum disorder not previously identified. Excessive and persistent anxieties or fears may signal separation or other anxiety disorders.

At the family level, parent–child interactions are key areas for observation and enquiry. Warm, nurturing relationships with responsive caregivers (especially parents or alternative main caregivers) are key protective factors for any child. Interruptions in care due to a parent's absence, poor mental or physical health or preoccupation with other priorities can contribute to disruptive behaviours. Family dysfunction, domestic violence, financial stress or illness in an extended family member can interfere with a parent's ability to maintain nurturing attitudes, daily routines and effective parenting practices, which are foundational elements in building and maintaining behavioural and emotional self-regulation. Reviewing current parenting practices and approaches to a challenging behaviour may elicit opportunities for intervention. For example, disruptive behaviour and anxiety may be a response to adult expectations that are too high for a child's cognitive abilities, particularly in a context where a child may have a global developmental delay. Behavioural patterns can change as parental figures or settings are altered, with behaviours differing across settings: between home and childcare, for example. Exploring such changes and differences can inform an understanding of etiology and indicate where best to intervene.

However, even after a systematic assessment is completed, some children are difficult to categorize as having the symptomology or degree of functional impairment necessary to establish with certainty that a disorder is present. The best approach in these situations may be to contract with the family for a series of regular visits to monitor the child's behavioural trajectory over several months. From a practical standpoint, the timing of a referral to specialty services depends on local access and wait times as well as on parental willingness to accept the referral.

Community practitioners provide front-line care by identifying problem behaviours and assisting families to access needed resources. The prevalence of mental health disorders among preschool children is similar to older children, at rates between 10% and 15%. However, there is evidence that paediatric care settings underidentify behavioural disorders in preschool children, as they do for school-aged children. Factors contributing to underdiagnosis include time constraints, lack of training in how to identify, evaluate and manage childhood psychiatric disorders, and the limited number and accessibility of specialists to whom children and families can be referred.

Opportunities for identification arise whenever parents express concern over a child's behaviour, emotionality, social skills or their own difficulties with parenting. Because there is often little time during regular office visits to explore socio-emotional health systematically, physicians should book additional time for assessment when warranted. Well-child visits are also opportunities to inquire about recent changes in a child's environment or the effectiveness of parenting style, if parents do not raise their concerns spontaneously.

Specific methods for exploring behaviour systematically are included in standardized health maintenance guides or as parent-reported screening measures. Such approaches are detailed in the following sections.

The Rourke Baby Record and ABCdaire

Current recommended practices in Canada for monitoring health and development in children ≤5 years of age are covered by the Rourke Baby Record (RBR) and ABCdaire (Université de Montréal). Using the RBR is recommended at well-child visits and is endorsed by the College of Family Physicians of Canada and the Canadian Paediatric Society. It was updated in 2014 to include guidance for developmental screening at the 18-month visit. Both guidelines support a systematic, comprehensive and unhurried approach to periodic evaluations of child development, including the identification and monitoring of health risks, particularly socio-emotional risk factors. It is especially important to ask parents whether they have any concerns about their children's behavioural or emotional functioning. Table 3 suggests some open-ended questions that can help to elicit information about a child's behavioural or emotional functioning across settings as well as to gauge associated distress for the child and family.

Table 3: Questions to elicit information about behavioural or emotional functioning

1. Do you (or any other caregiver) have difficulties encouraging your child to do as you ask?
2. Has a preschool teacher (or childcare staff member) ever mentioned concerns about your child's readiness to start school?
3. Do you have any concerns about your child's ability to communicate or learn new skills?
4. Do you have any concerns about how your child gets along with other children at home or in the community?
5. Do you have any other concerns about your child's emotions, behaviour or social functioning?

Standardized Screening Measures

Using standardized screening measures can help to assess for and identify problematic disruptive behaviours or the symptoms of mental health problems in preschool children. Most questionnaires can be completed by a parent or other primary caregiver or by teachers or childcare providers. Some practitioners prefer to have the questionnaire filled out before an appointment targeting behaviour issues, such that items can be reviewed during the assessment.

Like many screening tests, they are more effective for ruling out significant problems than for confirming a diagnosis. Some measures are best used for case-finding, that is, to help identify children who need further systematic assessment. Others, such as the Child Behaviour Checklist, can be used within a diagnostic assessment to quantify dimensions for a broad range of problems. As with other screening procedures, using a standardized screening measure to assess for disorders in this age group can lead to false-positive and false-negative results. False-positive risks include parental anxiety that their child may have or may develop a serious behaviour disorder; the stigma associated with mental health interventions; and the risks of referral to a specialist for an unnecessary assessment or intervention. False-negative risks include prolonged, negative parent–child interactions; delayed treatment leading to more expensive and time-consuming interventions in the future; and missed opportunities to prevent or mitigate negative academic, social and mental health impacts. The evidence is not yet sufficient to support the routine use of standardized measures in the early identification of mental health problems in children. However, advocacy toward much earlier identification and intervention is an important direction in current public health policy.

Initial Interventions

Preliminary recommendations for management should be guided by issues identified in the initial screening and assessment. First initiatives may include designating appointments to complete aspects of the systematic assessment, referral to a specialist and/or early intervention attempts. For children whose behaviours fall within the borderline or at-risk range, or that appear to be normative, anticipatory guidance for parents on effective discipline and psychoeducation (including directed reading) may be adequate. Topics can include age-appropriate expectations, the benefits of daily routines and the need for parents and other caregivers to be consistent in their expectations of a child’s behaviour.

For children with problematic disruptive behaviours, evidence-based parent behaviour training programs are typically the first-line intervention recommendation. Parent behaviour training may be offered in individual or group formats and should provide for intensive parenting skills development using explicit instruction, modelling, practice and feedback. Shifting established parenting patterns and developing new, more effective skills to manage significant disruptive behaviours can be difficult, even for competent parents. Parenting skills taught in evidence-based group programs are summarized in Table 4.

Training format	**Parenting skills taught**

1. Interactive, collaborative group
2. Peer support
3. Description of key parenting principles
4. Discussion of developmentally appropriate expectations
5. Observation of parent–child interactions
6. Modelling parenting skills (by others)
7. Practising parenting skills (role play)
8. Homework assignments to practice with child
9. Reframing unhelpful concepts about child management
10. Reframing unhelpful patterns of thinking about the child

1. Ensure positive and nurturing parent–child interactions
2. Set developmentally appropriate expectations for the child
3. Provide clear, consistent expectations, limits and routines
4. Identify triggers for positive and negative behaviours (e.g., fatigue, hunger, disappointment)
5. Use positive parenting skills such as giving salient rewards (e.g., praise or affordable items/activities) for select positive child behaviours
6. Reduce negative or harsh parent–child interactions
7. Ignore negative behaviours that are minor (i.e., ‘Pick your battles’)
8. Implement time-outs selectively (i.e., for specific behaviours such as hitting) with clear parameters (e.g., limited duration of time in time-out)
9. Work as a team with other parents and caregivers
10. Communicate with childcare staff or schoolteachers

A 10-session parent behavioural training program has been implemented successfully in community paediatric practices, with disruptive preschoolers benefiting from improved parent–child interactions and improved behaviours (compared with wait list controls) 12 months after the program finished. However, few practices in Canada have the resources to provide such a program ‘in-house’. Referral to a formal program should always be considered.

A range of evidence-based parenting programs are available in Canada, depending on where families live. These include ‘Triple P’, the Incredible Years Parent Programs and programs offered in remote and rural areas through Strongest Families. However, it is important to recognize that while all these programs have evidence of effectiveness, not all children with significant disruptive behaviours—or their families—benefit from such interventions. Also, they may not be sufficient as ‘stand-alone’ interventions for some families. Other programs may be available in communities across Canada, and practitioners should familiarize themselves with local resources, what services they deliver and evidence for their effectiveness. However, underfunded and underevaluated parenting programs are common in Canada.

While not all children and parents respond to first-line parenting interventions, they can still provide significant ‘scaffolding’ for positive behaviour change and are a basic building block of mental health care for children with disruptive behaviours. For children who are disruptive

primarily in preschool or childcare settings, evidence-informed behavioural interventions have been designed for educators as well.

In exceptional cases, medication may be considered for use in combination with behavioural approaches. While there is some evidence for the safe and effective use of medications in this population, practitioners should generally refrain from prescribing pharmacotherapy for a disruptive disorder without first trying an evidence-based behavioural intervention. Clinical experience suggests that children who do not respond adequately to an appropriately implemented parent behavioural training program may have a particularly severe disorder, a complicating comorbidity, a mistaken diagnosis, or a particularly complicated psychosocial environment. Examples of the latter include children who have witnessed interpersonal violence and/or have experienced physical or sexual abuse requiring additional intervention and/or the involvement of child welfare authorities. A parent with a psychiatric disorder can be a particularly challenging situation that requires separate and/or complementary interventions and timely referrals to more specialized and intensive psychosocial and community supportive services.

Summary

Disruptive behaviours can be a major challenge for parents, caregivers and their preschool children. They may also be a ‘marker’ for current or future mental health risk. Problematic disruptive behaviours can cause distress, impair functioning and development, restrict family activities, compromise peer relationships and limit access to quality childcare. Exploring the intensity, frequency and characteristics of difficult behaviours, along with an evaluation of adaptive functioning, will help to determine which problems may be transient and developmentally normal and those that require focused attention or intervention.

Recommendations

The following recommendations are based on current clinical consensus and will be periodically reviewed as new evidence becomes available. As part of routine care for children 2 to 5 years of age, practitioners who see children and families in practice should:

- Always enquire about social, emotional and behavioural concerns during periodic health examinations. Book additional time to complete assessment when needed.
- If concerns are identified, use standardized measures to help determine whether behaviours fall within the normative, borderline or at-risk, or clinically significant range. Screening tools can complement clinical assessment when determining the need for further evaluation or intervention.
- Consider evidence-based parent-training programs as a first-line intervention for children with significant disruptive behaviours.
- Provide anticipatory guidance and psychoeducation to parents, including directed reading, when a child’s behaviours fall within the borderline/at-risk range.
- Refer to specialized, more intensive services for children with significant behaviour problems complicated by comorbidity or not responding to first-line interventions.

Addressing Challenging Behaviors

Instructions

Brillante (2017a) discusses ways to address challenging behaviors in the classroom setting. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Pamela Brillante in *The Essentials: Supporting Young Children with Disabilities in the Classroom.* 2017a

There are times when all children behave in ways that are not easy to deal with. Every young child has times of fussiness or outbursts as he asserts his independence, tests boundaries, and learns to communicate with others. When toddlers lack the language they need to tell adults what they want (food, a toy, attention), it is not unusual for them to use tantrums, or perhaps even biting, for a short time to express their wants and needs. Most adults are not overly concerned about these kinds of behaviors because they happen infrequently and are often easy to stop or redirect for most children.

As children mature and parents and teachers model and teach effective ways of communicating and handling strong emotions, most children develop the necessary skills to interact with others and control their impulses. For some children, however, challenging behaviors are more intense, long lasting, or more frequent than expected for their age, and this can interfere with learning and social relationships.

Many children without disabilities exhibit challenging behavior, and many with disabilities do not. If a child with a delay or disability is exhibiting challenging behavior, it is not necessarily linked to their delay or disability. Understanding *why* the behavior is occurring and looking at the behavior in the context of what you know about the child and about children's development in general enables you to support the development of skills the child may be missing (how to appropriately get an adult's attention, how to communicate frustration in non-hurting ways) and, ultimately, more appropriate behavior.

What Challenging Behavior is Saying

Understanding several basic ideas about difficult behavior in young children can help you understand why it is occurring, which is the foundation for helping to change it.

Behavior is always a form of communication. Everyone communicates something through their behavior, most of the time without realizing it. Both positive behavior and challenging behavior express something about us and the way we are feeling at that moment.

There is *always* a reason for challenging behavior. Children use challenging behavior for one of two reasons: to get something they want (such as a toy another child is playing with) or to avoid something they *don't* want (like having to engage in a difficult task).

Challenging behaviors continue because they are effective. Young children continue to use challenging behavior because it gets them what they want or lets them avoid what they don't want. If it didn't work, they would not continue to engage in it. It may take longer to work sometimes, but as long as a behavior helps children achieve their goal, they will continue to use it.

Challenging behavior often indicates that a child lacks skills in some area. Unless you understand the reason for a behavior and address it, the child will not learn what he *should* do instead of the behavior. For example, if a child throws something because he is upset that a step in the daily routine was skipped and he cannot communicate this in any other way, he does not learn what he should do the next time this situation occurs if you simply remove him from the situation and take away a privilege. In addition, a new challenging behavior may replace the first one. You may be able to stop the throwing, but he may start kicking instead. You must identify what the child is trying to communicate and teach him how to express himself in ways that are more acceptable and that still allow him to achieve his goal. Focus on teaching those missing skills rather than getting a behavior to stop.

If you focus only on reducing a behavior, you may be removing the only way a child knows how to communicate with you (Neidert, 2003). Help children learn positive, effective ways to express themselves, communicate their needs, and regulate their feelings and actions.

Changing Challenging Behavior

There are many reasons challenging behavior occurs, but in every case, the child has a specific reason or function for exhibiting that particular challenging behavior. Understanding the function of a behavior is key to changing it. To begin, look for ABC:

- **Antecedent**, or what happens just before the behavior starts.
- **Behavior**, or what the behavior looks like, described in observable, measurable terms ("kicked chair five times" instead of "had temper tantrum").
- **Consequence**, or what happens just after the behavior ends (TCDD, 2013).

Conducting a **functional behavioral assessment (FBA)** using ABC helps you identify and understand the real reason a behavior is occurring and decide how to replace the challenging behavior with more acceptable behavior. Often, this is accomplished by teaching skills the child has not yet developed.

FBA consists of the following steps:

1. **Identify and describe the behavior in observable and measurable terms.** Behaviors like biting are observable and measurable; different people can agree on what biting looks like and count how many times it occurs. Descriptors like "acting out" or "being difficult" do not provide observable and measurable behaviors; not everyone agrees on

what those behaviors look like, so you cannot necessarily count how many times a child is being difficult.

2. **Collect data.** Data collection is necessary to document the behavior - specifically looking at the ABC of the behavior. Without accurate data, you may never discover the true reason behind it or know if the behavior is really gone. The child may stop throwing blocks, but he may start pushing other children. The behavior isn't gone, it just changed. Collecting data takes time and requires your undivided attention on the child, so work with another adult to help you with this step.
3. **Develop a hypothesis or hypotheses.** Look at the data you've collected and determine the function of the child's behavior. What is the child using the behavior for?
    - **To get something**, including an object, a person, a preferred activity, attention from adults or peers, or a preferred sensory stimulation, like being rocked or held by an adult.
    - **To get away from something**, including demands, activities, people, social interactions, or non-preferred sensory stimulation (pain or discomfort) (TACSEI, 2011).
4. **Develop and implement a behavior intervention plan.** A **behavior intervention plan (BIP)** is a plan that's based on the hypothesis you develop through the FBA process. The BIP is designed to teach a child missing skills or replacement behaviors that are more appropriate, and that the child can reasonably be expected to learn at this stage of his development. The plan should also include reinforcing the child's use of the appropriate replacement skill (Chazin & Ledford, 2016). Include the child in the development of the plan as much as you can. Ask him what he wants to see happen to make it better - what he comes up with may surprise you!
5. **Gather additional data.** Once you have started an intervention, continue collecting data to see whether the intervention is working, or you need to adjust something. This part takes time, and change will not happen overnight. You may not have correctly identified the behavior's function, indicating your replacement skills are not correct and you need to rethink your hypothesis.

Conducting an FBA and writing a BIP based on the information you collect is the best way to help a child learn the skills he is missing and to prevent behaviors that arise from this lack of skills. Once you understand the real reason for the behavior, you may find it relatively easy to replace those challenging behaviors with positive ones. Collecting data lets you know whether the plan is working, even if it is in very small steps. Realize that behavior may actually increase after you start trying to replace it before it decreases. Be consistent in applying your intervention and remember to recognize and reinforce the new behavior.

Sometimes there are other reasons for challenging behavior that make it difficult to understand and resolve, such as medical issues (earaches) or changes at home (new baby, loss of parent's job). If behaviors are not diminishing, step back and look for a new hypothesis or a connection you've missed. Behavior is a puzzle, and puzzles are not always solved on the first try!

Preventing Challenging Behaviors

Instructions

Brillante (2017d) discusses how to prevent challenging behaviors - which is always a better solution to having to intervene when behaviors become challenging. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Pamela Brillante in *The Essentials: Supporting Young Children with Disabilities in the Classroom.* 2017d

Prevention strategies can address many of the challenging behaviors children exhibit. Often, you can prevent some challenging behaviors by changing your practices.

Changing Classroom Environments, Routines, Schedules, and Transitions

- Have consistent basic schedule and regular morning routines. A predictable routine helps children understand what to expect next, which makes them more relaxed and cooperative as well as independent.
- Make sure all materials and activities are developmentally appropriate (and accessible) to foster independence. Providing appropriate choices so children have some control over their activities encourages initiative and independence and helps them focus on learning.
- Reduce the number of transitions a child has to make each day, and have a routine around each transition (like a song) so you can teach her how to transition and what your expectations are. For example, sing the expectations of transition ("If you're finished cleaning up, choose a book!") to the tune of "If you're happy and you know it." Model and have her practice choosing a book to look at when she's finished cleaning up after center time.

Using the Power of Peers

- Use peers to model appropriate social behavior.
- Set up the classroom routines and activities so they support peer buddies (line up together, talk to your partner about your answers, have a lunchroom buddy).
- Choose buddies intentionally; some children make better partners than others. Do not always choose the most socially advanced child; look for one who is sensitive to the overall skills of a child with a disability.

Teaching Social and Emotional Skills

- Model taking turns, sharing, and other social skills, such as comforting a classmate who is upset.

- Teach children how to problem solve and negotiate when sharing materials.
- As a group, come up with no more than three to six clear classroom rules that state what children *should* do, rather than what they should *not* do (for example, "Use gentle touches" instead of "No hitting").
- Teach the rules and have children practice them in context.
- Have clear consequences for not following the rules and enforce them fairly and consistently with all children.
- Acknowledge and reinforce appropriate behaviors and positive child interactions ("Keyonte, that was kind of you to pick up Devon's marker for her"). Catch children being good!

A child with a delay or a disability is a child who has the same needs as other children do, including the need for an education. Education is a human right and should be accessible for every child without discrimination (UNICEF, 2009).

Planning for Positive Guidance: Powerful Interactions Make a Difference

Instructions

Sanchez, Steece-Doran, and Jablon (2013) discuss how positive guidance can be used to support children with special needs in the early education classroom. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Danielle Degel Sanchez, Deborah Steece-Doran, and Judy Jablon. 2013.

Guiding children's behavior is something done throughout the day, not just when a child acts in a way that is unsafe or unacceptable. You guide behavior by establishing predictable routines, setting clear rules with children, and modeling kindness and respect. You are also attentive and aware of what is going on. Together, these actions help children feel noticed, confident, and secure. Children experience your attention and guidance as a caring embrace holding everything together. They know you're on their team. (Dombro, Jablon, & Stetson 2011, 58)

This excerpt shapes our thinking as we plan for positive guidance in our classroom at a preschool in Pahoa, Hawaii. Using the three steps of a Powerful Interaction—Be Present, Connect, and Extend Learning—helps us be more successful at building strong, caring relationships with children and families. Powerful Interactions are interactions in which a teacher intentionally connects with a child to extend his or her learning. We also actively plan for guidance, which keeps a positive climate in our classroom. This boosts how we feel at the end of the day and enhances each child's success as a learner.

Here are some strategies we use to plan for positive guidance, keeping a Powerful Interactions approach in mind.

Teamwork makes positive guidance more effective and Powerful Interactions possible!

It took time for us to become an effective teaching team. We had never worked together and had to become acquainted with each other's teaching style. However, we wanted to be a seamless team because children tune in to their significant adults. We strive to coordinate our messages to children and make them clear and consistent. By staying present (step one of a Powerful Interaction) with each other and connected with our eyes, words, laughter, and other cues, we extend children's learning during group times and transitions. Our teamwork has positive effects on children's behavior and the classroom climate. It also gives us more energy to guide children in positive ways and enjoy each day. Three tips help us ensure seamless teamwork:

1. **Be clear about roles.** When we plan together, we clarify who will do what and when. Our goal is to be predictable about our roles during routines so that the children can anticipate what's going to happen and who to look to for directions. This reduces challenging behaviors significantly. For example, at arrival time, Deborah greets children in our lending library and talks with them about books. At the same time, Danielle greets children and families at the classroom door and then moves around the room to support them as they do morning activities.
2. **Make two voices one, literally and figuratively.** This helps us deliver clear and cohesive messages to children. Too often children check with one adult and if they don't like the answer, ask the other one. When children hear our voices from different areas of the room, they are more relaxed. We're playful and sometimes silly about how we make our two voices one. We might echo each other's voices melodically, complete each other's sentences when giving directions, or finish each other's rhymes. Danielle says, "There was one little bat in one big cave," while looking over at Deborah who immediately chimes in, "He was so alone and not so brave." The children enjoy the predictability of listening for our voices bouncing back and forth. Sometimes they look at the other adult to see what she'll say.
3. **Use frequent check-ins.** We continually check in with each other throughout the day about what children are doing and how they are responding to activities and other children. We give each other signals about how things are going. The more we stay present, the easier it is to connect with each other. The result is a calmer classroom and fewer episodes of challenging behaviors. These tips have worked for us:
    - Be on opposite sides of the room during indoor time to keep things running smoothly.
    - Scan the room frequently, looking at what children are doing and at one another. Quickly read each other's cues, such as a thumbs-up, smile, nod, or lift of an eyebrow.
    - Update each other after an interaction with a child or family member. A quick summary or saying "Remind me to tell you about _____ later today" ensures consistency with each other, the children, and their families.

- Tune in to those children who need a little more attention. This can prevent challenging situations by catching them before they start.

Use daily arrival time to set the tone for positive guidance.

At the beginning of the year, teachers get to know children and their families through home visits and an orientation period (when a few children come for a few hours each day). During the orientation we introduce our arrival time routines. Our goal is for parents to have positive interactions with their children and for us to have Powerful Interactions with children and family members. Our routine and roles allow us to be present and connect with each child and her family for at least a few minutes. We plan activities that address positive guidance as well as language and literacy and math learning. When the day begins well, most children stay engaged and focused. Our predictable routine has three parts:

1. **Offer specific activities in learning centers.** We display simple written directions for activities parents and children can do together. While completing the activities is not required, parents and children often do them because they are engaging and they spark ideas to use at home.
2. **Write an interactive morning message.** The daily message is for families to read to their child as the child points to each word. Part of the message specifically relates to positive guidance. In Hawaiian culture and in our program, we emphasize the values of aloha (kindness), malama (caring), and kuleana (responsibility). To engage families and children in discussion, one question invites reflection about one of these three values. For example, the message might ask, What's one way that you will show malama today? A family member helps the child answer the question, records his answer on a Post-it note, and adds it to a message chart that is on display for the week. Additional messages might ask, "How many letters are in your name?" or "Who brought you to school today?" We discuss the daily message when we gather for group time later in the morning.
3. **Create a library.** To encourage Powerful Interactions at home, we set up a lending library. Books are arranged in categories (that change periodically) so children can return their book in the morning and make a new selection. Children enjoy talking with Deborah about the books they return and hearing her recommendations for new selections.

Ensure smooth transitions.

As a team, we sustain a warm and friendly classroom climate by planning for and using teamwork to ensure smooth transitions. Over time we have established a repertoire of successful strategies in three main categories:

1. **Humor.** A light tone gives us energy and invites positive responses from children. Whether it is simply laughing aloud, making up a silly rhyme to give a direction, or singing funny words to a familiar song, we keep our transition times light and engaging. Sometimes we're laughing at each other and our own silliness, which makes the children laugh, too.
2. **Puppets.** When we gather on the rug between activities, we each wear a finger puppet. The puppets talk about what will happen next, what they observed about cleanup, or the behaviors expected in the next activity. The children know these puppets well and seem completely invested in listening to them. Daisy: Hey Fuzzy, I used my walking feet when I came over to large group. Fuzzy: Me too. We know our kuleana (responsibilities), don't we!
3. **Music.** Songs and melodies add to the positive climate. When interacting with one child at a time, we use natural, authentic voices. However, when we want to engage the whole group, we find that singing directions captures their attention more than our normal voices. These strategies work for us:
    - Give verbal directions in a melodic voice.
    - Use call-and-response or rhymes or something that allows voices to alternate. When we sing songs that have an echo pattern—like "Down by the Bay"—the children know to expect our voices to alternate.
    - Give directions as lyrics to a familiar song and alternate voices. For example, as it gets close to cleanup, Deborah starts singing to Danielle to the tune of "If You're Happy and You Know It."

Deborah: *Kumu* (teacher) *Danielle, are you ready to ring the chimes?* (2x)

Danielle chimes in,

Yes I am and I'm walking over now

and I am ready to ring the chimes.

Deborah then begins the next verse as she guides the children in cleaning up, and Danielle moves toward the rug to help settle children.

Remember what to do when you hear the chimes . . . (2x)

We clean up our activity,

and walk over to our name,

and sit right down and show Kumu Danielle that you're ready.

We have shared the ways we plan for positive guidance and use Powerful Interactions in our classroom to create a positive climate that prevents many challenging behaviors. The result is an enjoyable, effective, and productive learning environment. We hope you find the suggestions effective and that they spark more ideas for helping children and families.

Challenging Behavior - Toddlers and Young Children

Instructions

This learning resource has information on how to support children. However, when dealing with actual behavior disorders, they are mostly diagnosed in later childhood since they are often caused by trauma in early childhood. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Kid's Health Info. 2018

Young children experience a range of emotions and express themselves in many different ways. It's normal for toddlers and young children to have tantrums and break rules while their social and emotional skills are developing.

It's important that you and other caregivers provide support while your child is developing and learning to manage their own emotions. Guiding your child and encouraging positive behaviours will help them learn appropriate ways to behave.

Signs and Symptoms of Challenging Behaviour

Different families will have different expectations about what is acceptable and what is considered difficult behaviour. Some behaviours that families commonly find challenging include:

- defiance (e.g. refusing to follow your requests)
- fussiness (e.g. refusal to eat certain foods or wear certain clothes)
- hurting other people (e.g. biting, kicking)
- excessive anger when the child doesn't get their own way
- tantrums.

What Causes Challenging Behaviour?

Challenging behaviour is sometimes due to your child not having the social and emotional skills they need to behave the way you would like them to. Often when a child misbehaves, it is a response to feeling anxious, angry or overwhelmed and they are struggling with processing these feelings.

Children need attention from their parents and carers to feel secure and thrive emotionally. Children may show challenging behaviours in an attempt to gain attention and responses from adults – for some children, even negative attention is preferable to no attention at all.

Young children are also easily distracted and have short memories, which may be why sometimes they don't do what you ask them to.

There are a number of other things that might affect your child's ability to control their reactions, emotions or behaviours, including:

- being unwell
- not enough sleep or being tired
- too much screen time
- poor diet or feeling hungry
- a change in family circumstances or routine.

Sometimes, ongoing challenging behaviour can indicate other health issues or an underlying developmental, social or emotional problem. It is also important to consider a child's current situation or environment and how it may be affecting them. If you are concerned about your child, see your GP.

As part of healthy development, toddlers will slowly learn to control how they react to different situations. As your child gets older, they will be able to understand more about what behaviour you expect of them and be better able to control their behaviour.

How to Deal with Challenging Behaviours

Setting rules is important so that your child knows what behaviour is expected of them. Keep your instructions simple and short (e.g. "No hurting other people."), and make sure your child understands what you have told them. It's also important to give a short and simple instruction about the behaviour you would like to see (e.g., "be gentle with your brother").

There are a number of options for discouraging challenging behaviours, such as:

- Ignoring – for minor attention-seeking behaviours, it is best to ignore the behaviour (e.g. turn away from your child and respond only when they stop doing it). Constantly responding to negative behaviours can teach a child that this is a good way to get your attention.
- Distraction – young children might stop the negative behaviour if given an appealing alternative.
- Encouraging empathy – point out how your child's behaviour is making another person feel (e.g. sad, hurt) and ask your child how they would feel if someone did the same to them.

Dealing with ongoing, more serious negative behaviour can be very stressful. It is best to guide your child's behaviour by using a positive approach.

Positive Reinforcement

A positive approach to managing your child's behaviour invloves rewarding good behaviours often and focusing on positive aspects of your child's behaviour, rather than directing attention to negative behaviours.

- Reinforce positive behaviours before they become negative (e.g. "I think you're doing a great job at playing gently with your brother"). This encourages your child by giving attention to their positive behaviour, rather than waiting until they become too rough and having to focus on the negative behaviour. Make sure you are specific about what behaviours you really like and want to encourage.
- Consider implementing a positive behaviour system in your home. A reward chart for younger children can add incentive for your child to increase desirable behaviours. This strategy can help you focus on the times when your child is behaving well.
- Be a role model for your child. Children pick up clues about how to behave from watching others. It's important to act and talk in a way that you'd like to see reflected in your child's behaviour – if you want to discourage your child from shouting at you, it is important to try to keep a calm voice when you are becoming frustrated.

Consequences for Negative Behaviour

If your child is breaking the rules, communicate to them that they are doing the wrong thing and, if appropriate, give them a second chance to correct the behaviour.

If the negative behaviour continues, there should be a logical, age-appropriate consequence that you are willing and able to carry through with (e.g. "If you don't stop snatching from your friend, you can't play with the cars anymore"). Immediate consequences are fairer and more effective than delayed consequences.

Time-out is a common way to deliver an immediate consequence, but it needs to be used appropriately to work well. Keep time-out as a consequence for more challenging behaviours

(e.g. deliberately hurting others, dangerous behaviours or deliberately breaking things) rather than behaviours that can be ignored (e.g. whinging, swearing).

Time-out should not be used to make the child suffer (e.g. isolating them for long periods), but can be used to remove your child from the situation for a few minutes and give them an opportunity to change their behaviour.

Generally, it is recommended that your child stays in time-out for a maximum of one minute for every year of their age, and that you allow them out of time-out when the time is up, even if they are not yet calm or quiet. Leaving your child in time-out or isolation for longer periods is likely to cause them to become more distressed.

If your child continues to misbehave after the time-out has finished, they can be put back into time-out for another session or two if their inappropriate behaviour continues.

Be consistent with your approach to consequences and your child will be more likely to understand what is expected of them.

Negative Discipline can be Harmful

Physical discipline

Physical discipline is anything that is done to a child to cause physical pain or discomfort in response to their behaviour. Physical discipline includes smacking, hitting, spanking, slapping, pinching or pulling.

Many studies have found that physical discipline can have long-lasting negative effects on a child, including:

- increased aggression and antisocial behaviour
- teaching children that violence is OK
- low self-esteem
- mental health problems
- a poor relationship between the child and parent.

Shouting or Shaming

Shouting or yelling may be an understandable response when parents are frustrated; however, studies have found that repeated shouting at children can have similar harmful effects to physical discipline.

Being shouted at – especially by someone much larger than them – is very stressful for a child. Shouting does not improve children's behaviour, and it can lead to more behavioural problems (e.g. increased aggression) and mental health issues (e.g. anxiety, depression) in the future.

Shaming, belittling and humiliating children for their actions is also very damaging to their long-term mental health, and not an effective way to improve their behaviour.

Isolation as Punishment

Spending long periods in isolation without explanation or emotional support can be harmful for young children. Being isolated (especially at a time when they are upset) can be perceived as rejection, which can cause distress and confusion for your child. At times it can be effective to take your child away from a challenging situation and have a quiet change of scene, but it is not helpful to keep them away for longer than the recommended period of one minute per year of age.

When to see a doctor

Sometimes, severe and persistent challenging behaviour can be a sign of a developmental condition or a more serious mental health concern. If your child's behaviour is affecting the way they cope with life you should see your GP for help and further assessment.

Behavioural challenges can have an ongoing, negative impact on family life. If you are having difficulties managing or coping with your child's behaviour, you can talk to a GP who may refer you on to a specialist in paediatric behaviours.

Key points to remember

- It's normal for toddlers and young children to have tantrums and break rules while their social and emotional skills are developing.
- Ignoring, distraction and encouraging empathy can help discourage negative behaviours.
- Positive reinforcement and focusing on your child's good behaviour is the best way to guide your child's behaviour.
- Setting rules and being consistent with age-appropriate consequences is important.
- Punishing your child with physical discipline (e.g. smacking), shouting or isolation can be harmful.

How to Manage Challenging Behaviour in Class

Instructions

Harrold (2018) discusses ways he supports children with challenging behaviors in the special education and/or inclusive classroom. Be sure to take notes since you are expected to incorporate quotes and references from the learning materials to support the points you are making in your original response to the discussion prompt as well as the assignments you complete throughout this course.

Learning Resource

By Mark Harrold. 2018

Children with special needs can often be held back by factors which are not related to the disability with which they are born. From an early stage in their development, they can be treated differently to their siblings and their peers. While they deserve the respect of being

treated the same as all children, it is often the case that rules are more likely to be relaxed. Expectations of appropriate behaviour can be lowered. In a word, children with special needs may be spoiled. Unfortunately, this can contribute to what is called “challenging behaviour”.

Most often, problems occur when a child’s unreasonable expectations cannot be met. Tantrums, refusal to cooperate, meltdowns or aggression are among the inevitable outcomes. The truth is that carers actually have to be more strict, rather than the opposite, when it comes to applying social norms for children with special needs. Here are some fundamental rules I follow in my work supporting children who challenge. They are as relevant for the classroom as they are for the home setting.

1. **Resist the temptation to spoil a child with special needs.** The last thing they need to think is that they are special. If they are afforded a status of privilege among peers or siblings, they will lose the resilience necessary to develop independence in their adult years. The same rules should apply to a child with special needs as to others. So avoid hugs with strangers or those with whom the child only has a passing acquaintance. While it may feel good for the recipient, it is not good for the child with special needs. Teachers and SNAs take note. If you don’t hug the other pupils, which I presume you don’t, no hugs for the child with special needs. This is a fundamental principle.
2. **A limited capacity to communicate can lead to frustration.** Many children are visual learners. Enhance communication by using visual prompts. They say a picture paints a thousand words. This applies particularly when it comes to enhancing communication with a child with special needs. Gestures, pictures, objects of reference, and mobile phones (yes, they are useful for some young people) are just some of the communication aids that are so vital.
3. **Have a basic set of rules set up with pictures as well as words.** No more than five items for children with special needs. These rules should instruct the children what *to do*, such as, “be kind to others”. Avoid rules telling them what *not to do*, such as “no spitting". All the child understands is what is presented, whether positively or negatively. Avoid spitting by not mentioning it at all! Make the rule all about what behaviour you are looking for.
4. **Praise good behaviour and be specific about what was so good.** It is not necessary to provide regular treats. Genuine praise is the most powerful reward available to carers. None of us gets tired of hearing our name in the context of a job well done. And it increases the likelihood that the positive behaviour will be repeated. This is universal.
5. **Ignore bad behaviour.** I have seen parents and teachers go out of their way to elicit an apology from a child with special needs following an incident of challenging behaviour. Let me be very clear. “Sorry” is the most redundant word in learning disability. Far too much time is wasted in pursuing it and it simply provides the child with a vehicle to receive more attention. Ignoring sends a far stronger message that you do not approve. Too often carers feel that they cannot allow an incident to go by without this ritual of seeking an apology. It is a waste of time.
6. **Same rules for bad behaviour.** If the consequence for bad behaviour in the classroom is that a child must stay in the classroom during yard time, this must also apply to the

child with special needs. Indeed, there should be a very low tolerance for acting out behaviour, and consequences should be applied immediately.

7. **Always keep raising the bar for children with special needs.** For example, the idea of everyone receiving a prize at sporting events denies them a necessary life experience, that is, is to learn how to overcome failure. Too often we deny children with special needs this very necessary learning process. In life we learn far more through failure than through success.
8. **Take small steps.** It may, at times, feel as if you are taking two steps forward and one back but keep going. Task analysis, breaking tasks down into small steps, is a useful strategy. It all contributes to moving forward.
9. **Plan ahead.** One of our greatest fears is the fear of the unknown. This is particularly the case for children with special needs. They are most secure with familiarity and routines. Always plan ahead and let them know what to expect. A visual schedule of activities works very well in any setting.
10. **Focus on structure.** Children with special needs are most likely to act out in situations where there is an absence of structure. Transition time at school is an obvious example. It is important for carers to put time into planning ahead. This will prevent problems or will lessen the impact should a problem arise. The best way to manage challenging behaviour is to aim to prevent it from happening in the first place.
11. **Break the bad habits.** Quite often some obvious habits go unchecked and lead to challenging behaviour. Poor diet, absence of a proper sleep routine, lack of clear communication, and absence of a detailed plan are just some of the errors which are all too common and which lead to problem behaviour.

Children with special needs have a place in our communities, our schools, our amenities. In order for them to integrate fully, we all need to be aware that they are far more like their non-disabled peers than different. They are not born with challenging behaviour. It is not an inevitable characteristic of a person with special needs. It is a learned behaviour which, with the right strategies in place, can be unlearned. By being aware of these strategies, carers can ensure that all children with special needs reach their full potential.

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