Teacher's Guide/Exploring Childhood

No Two Alike

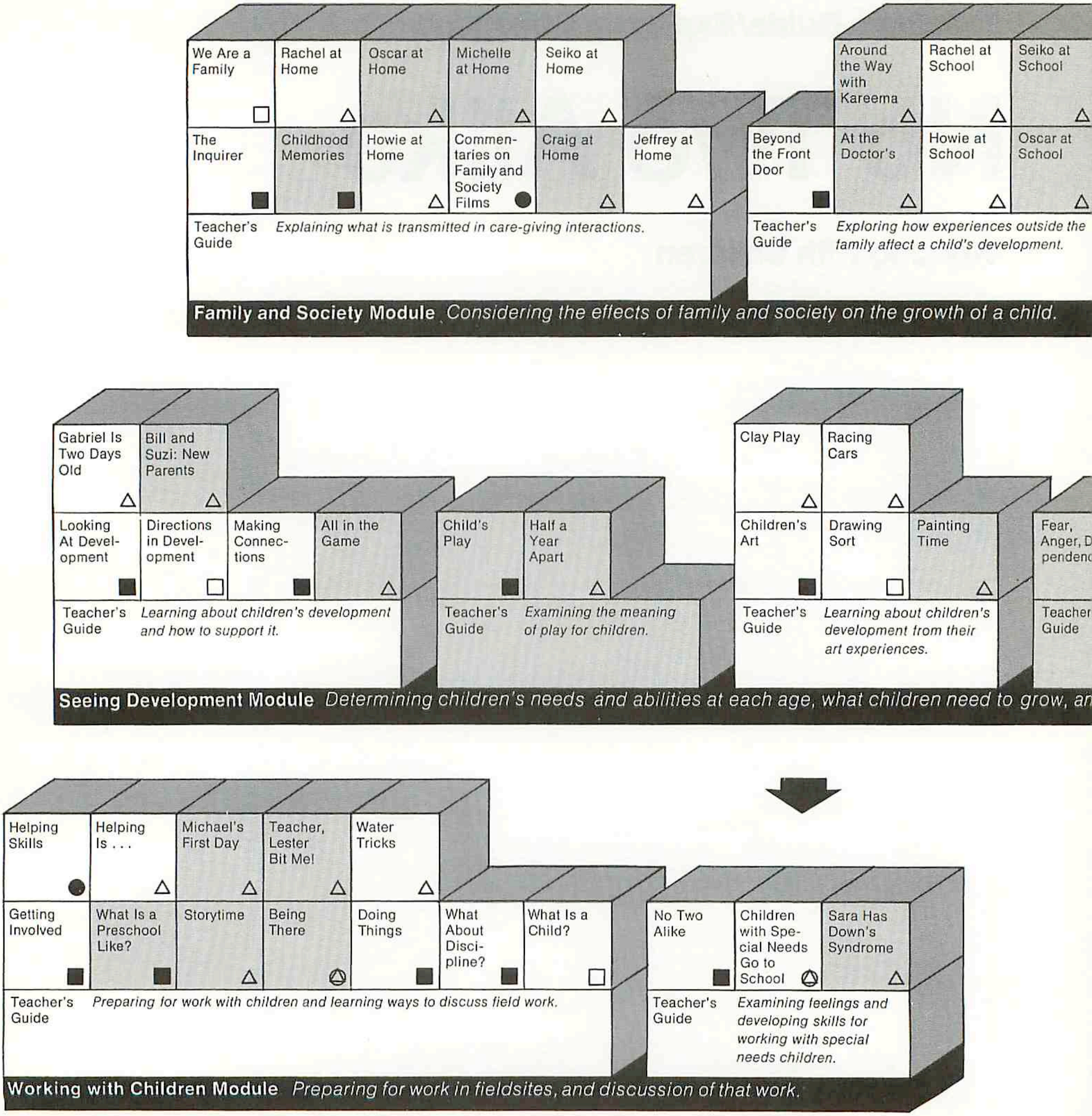
Working with Children

Teacher's Guide/Exploring Childhood

No Two Alike

Working with Children

EDC
School and Society Programs
15 Chapel Street
Newton, MA 02160



We Are a Family □
Rachel at Home △
Oscar at Home △
Michelle at Home △
Seiko at Home △
The Inquirer ■
Childhood Memories ■
Howie at Home △
Commentaries on Family and Society Films ●
Craig at Home △
Jeffrey at Home △
Teacher's Guide *Explaining what is transmitted in care-giving interactions.*

Around the Way with Kareema △
Rachel at School △
Seiko at School △
Beyond the Front Door ■
At the Doctor's △
Howie at School △
Oscar at School △
Teacher's Guide *Exploring how experiences outside the family affect a child's development.*

Family and Society Module *Considering the effects of family and society on the growth of a child.*

Gabriel Is Two Days Old △
Bill and Suzi: New Parents △
Looking At Development ■
Directions in Development □
Making Connections ■
All in the Game △
Teacher's Guide *Learning about children's development and how to support it.*

Child's Play ■
Half a Year Apart △
Teacher's Guide *Examining the meaning of play for children.*

Clay Play △
Racing Cars △
Children's Art ■
Drawing Sort □
Painting Time △
Teacher's Guide *Learning about children's development from their art experiences.*

Fear, Anger, D
penden
Teacher
Guide

Seeing Development Module *Determining children's needs and abilities at each age, what children need to grow, an*

Helping Skills ●
Helping Is . . . △
Michael's First Day △
Teacher, Lester Bit Me! △
Water Tricks △
Getting Involved ■
What Is a Preschool Like? ■
Storytime △
Being There ◬
Doing Things ■
What About Discipline? ■
What Is a Child? □
Teacher's Guide *Preparing for work with children and learning ways to discuss field work.*

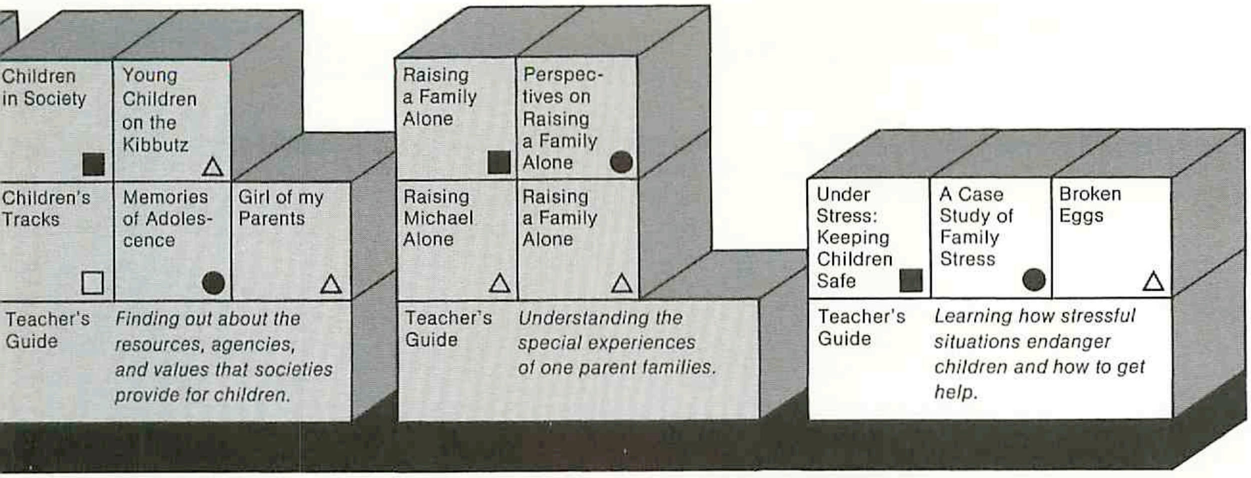
No Two Alike ■
Children with Special Needs Go to School ◬
Sara Has Down's Syndrome △
Teacher's Guide *Examining feelings and developing skills for working with special needs children.*

Working with Children Module *Preparing for work in fieldsites, and discussion of that work.*

Exploring Childhood

Key

■ Booklet
□ Poster
⧄ Cards
△ Film
● Record
▲ Cassette
◬ Filmstrip and Record



Children in Society ■

Young Children on the Kibbutz △

Children's Tracks □

Memories of Adolescence ●

Girl of my Parents △

Teacher's Guide *Finding out about the resources, agencies, and values that societies provide for children.*

Raising a Family Alone ■

Perspectives on Raising a Family Alone ●

Raising Michael Alone △

Raising a Family Alone △

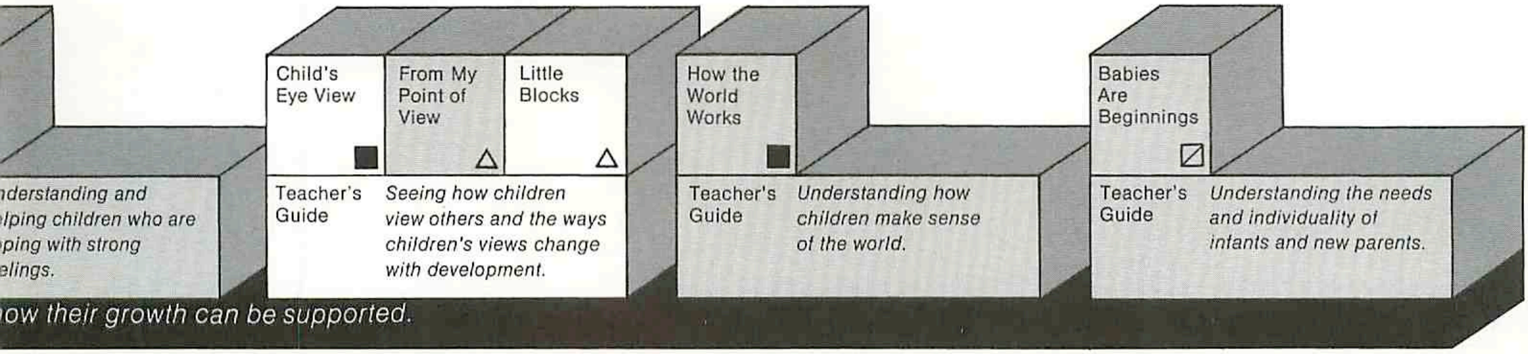
Teacher's Guide *Understanding the special experiences of one parent families.*

Under Stress: Keeping Children Safe ■

A Case Study of Family Stress ●

Broken Eggs △

Teacher's Guide *Learning how stressful situations endanger children and how to get help.*



nderstanding and lping children who are ping with strong elings.

Child's Eye View ■

From My Point of View △

Little Blocks △

Teacher's Guide *Seeing how children view others and the ways children's views change with development.*

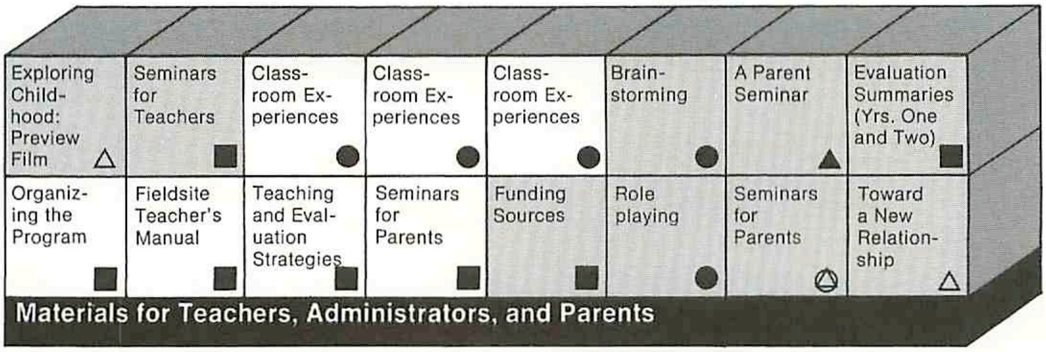
How the World Works ■

Teacher's Guide *Understanding how children make sense of the world.*

Babies Are Beginnings ⧄

Teacher's Guide *Understanding the needs and individuality of infants and new parents.*

ow their growth can be supported.



Exploring Childhood: Preview Film △

Seminars for Teachers ■

Classroom Experiences ●

Classroom Experiences ●

Classroom Experiences ●

Brainstorming ●

A Parent Seminar ▲

Evaluation Summaries (Yrs. One and Two) ■

Organizing the Program ■

Fieldsite Teacher's Manual ■

Teaching and Evaluation Strategies ■

Seminars for Parents ■

Funding Sources ■

Role playing ●

Seminars for Parents ◬

Toward a New Relationship △

Materials for Teachers, Administrators, and Parents

☐ Full Year Course Selection

▨ Supplementary Materials

Contents

Introduction

In recent years, many states have enacted legislation entitling all children, whatever their emotional or physical needs, to a full education. A 1972 congressional mandate required that at least 10% of the children enrolled in Head Start be children with special needs. This means that more and more Head Start programs and kindergartens are including special children, and that teachers are learning to make room for such children in their classrooms.

Many Exploring Childhood students will find children with special needs included at their fieldsites, or they may choose to work at sites set up especially for such children. *No Two Alike: Helping Children with Special Needs* has been prepared to help these students and their teachers to think about the particular emotional issues and skills involved in such work. A second major goal of this material is to help students deal with the sometimes threatening issue of "difference" in human beings--difference as it occurs in themselves, in the children they work with, and in the children they will care for in the future.

Defining "Special Needs"

There are many kinds of special needs, both physical and emotional. Each type of special need varies from slight to severe: e.g., a person who wears glasses (visual disability) may find that winter sports are difficult because glasses fog in the cold, while a blind person will not be able to do "visual" things at all without special aids. Some conditions, such as being albino, do not interfere with our activity at all, but constitute handicaps because of the way people react to them. In trying to decide whether a child needs special attention, we should consider one critical factor: how do others treat the child?

A special need may be a serious impediment to one person, and not pose any problems to another. While some children are emotionally secure, well adjusted, and able to relate to other people, other children may *feel* handicapped, insecure, or isolated. Such children have special needs: physical or emotional, or both.

While all children have problems adjusting, some children have a more difficult time because they have substantive physical or psychological differences from their peers. Some children need special attention for only an hour or a day; other children need it over long periods of time.

In giving them this attention, we should be careful to avoid labeling them "handicapped," a negative term that can only limit them in their emotional development or in their relations with others. *No Two Alike* focuses on children's *needs*, rather than on their "handicaps."

Integrated Programs

In the ideal situation, all children are dealt with as individuals, and no child is excluded from the classroom. But the goal of integrating all children into one classroom and expecting to meet all of their needs may be unrealizable. The case of Jim, the blind ex-soccer captain (p. 14), is an example of the difficulty of integrating students with widely different needs. The ratio of students to teachers often makes it impossible to give students the amount of attention they need. If these problems can be overcome, we believe that the advantages of having no child labeled a special case surpass the difficulties of making room for all children. (See p. 23 of student booklet for arguments for and against the public school integration of children with special needs.)

Choosing to Work with Special Needs

Rather than trying to judge which students might be suited to work with children with special needs, teachers should consider how to help students decide for themselves if they are suited. *No student should be placed in a site with children with special needs without having been involved in the decision.*

You can aid students in their decision by arranging observation time at sites with children with special needs (p. 13), by helping students to air their expectations ahead of time (p. 9), by helping them to set realistic goals, and by making it possible for students to change their placement if, after long thought and discussion, they are unhappy with the work.

Involving the Fieldsite Teacher

Close cooperation and communication between course teacher, the teacher of the children students work with, and students is especially important in cases where students are working with children with special needs. The course teacher may find that the fieldsite teacher is a valuable consultant for help on how to discuss special needs in the classroom. The fieldsite teacher may be able to:

- visit the classroom to discuss particular issues with students;
- make suggestions about using *No Two Alike;*
- discuss and demonstrate the kinds of roles a teacher can play in working with children with special needs;
- help students decide whether to work with special children, and whether a particular child might benefit from a one-to-one relationship;
- offer advice and support;
- help students evaluate their progress.

The fieldsite teacher will have information he or she may wish to share about the diagnosis of a child's particular needs, the way the parents meet those needs, and the methods the school has used to meet those needs.

Involving Parents

Because parents of children with special needs are often especially concerned about their child's progress at school, students working with such children may find themselves in greater contact with parents and may need the support of course and fieldsite teachers in approaching this relationship.

Students should come to see that close communication between the school and parents can be mutually helpful. Parents can share the diagnostic information and advice they have received from professionals such as doctors, psychologists, social workers, or physical therapists. They can help the school learn what their child is like--what his or her particular strengths and needs are. They can also keep the school informed about how their child is progressing, and what approaches they use at home for such matters as reward and punishment.

The school, on the other hand, can tell parents about their child's achievements, activities, and problems at school, so that parents can follow up on them at home. Because they see children engaged in activities and accepted by other children, teenage helpers and the teacher can often give parents a new perspective on their child's abilities. The school can also offer parents a place to communicate with other parents, to share anxieties, and to realize that theirs are not unique problems.

The students, like the fieldsite teachers, can facilitate the relationship between the parents and the school by sharing what they have learned about the children with the parents, and by seeking the parents' advice on difficult problems.

Organization of the Student Booklet

No Two Alike is divided into six major sections.

1. "Raising Some of the Issues" considers work with children with special needs by observing and examining the feelings of those with special needs, and by looking at our own initial reactions and expectations.

2. "Making Room for Children with Special Needs" presents first-person accounts, a film ("Sara Has Down's Syndrome"), and news and magazine clippings, in order to consider how fieldsites, families, and communities can adapt to meet special needs.

3. "Meeting the Children" presents seven case studies of children with a range of special needs--physical, emotional, and mental. More detailed medical information on these needs is given in the appendix to this guide (p. 68).

4. "Building a Relationship: The One-to-One Model" presents one teenager's experience, and describes the process of working closely with one child.

5. "Building Skills and Self-Esteem" suggests specific teaching methods to use with children with special needs, and describes how these methods can be adapted to a variety of needs.

6. "Additional Help and Information" suggests people, institutions, and books that can serve as resources to people working with children with special needs, and offers a glossary of medical terms. This section can be further supplemented with the list of resources on pages 50-55 of this guide.

How to Use *No Two Alike*

Most classrooms will have only five copies of *No Two Alike*. You may choose to use the booklets with the whole class, with a few students who choose to work with children with special needs, or with a combination of the whole class and individual students. You might use parts of the booklet in a few weeks, or you might refer to the book as a resource throughout the year. The following suggestions outline a few of these options.

With the Whole Class

Many students can use a few booklets by:

- having short sections read aloud to the whole class (e.g., the Lilly or Glenda stories in "Raising Some of the Issues");
- having exercise directions read aloud for the whole class to do (e.g., "Listing Feelings").
- dividing the class into small groups, giving each group one booklet (e.g., each group could do one of the five exercises in "Making Room in the Fieldsite," later reporting to the class);
- having the teacher summarize and lead an exercise (e.g., viewing and discussing the film "Sara Has Down's Syndrome," or collecting news clippings for a reference scrapbook);
- giving reading assignments over a long period of time and asking students to pass the booklets on to other students.

With Individual Students

Students who have chosen to work with children with special needs will be especially interested in using *No Two Alike* intensively. You can arrange for such individual work by:

- having students take notes and answer questions in their journals, which they might exchange or share with you;
- assigning different sections of the booklet at appropriate times in the student's work (see chart below);
- assigning students who are working with particular special needs to read relevant case studies (pp. 43-58), sections of the glossary, or other anecdotal material in the booklet;
- giving extra credit to students who do research on causes and treatments of particular special needs, or on community resources that serve people with special needs;
- giving extra credit to students who collect news items for a reference scrapbook and discuss issues raised by the items with the class;
- giving extra credit to students who report to the class on their work with children and/or arrange for speakers to visit the class;
- providing time for those students working with children with special needs to meet together in small groups to share experiences, discuss readings, plan projects, or prepare presentations for the class.

SECTION	CAN BE ASSIGNED
"Raising Some of the Issues" "Making Room at the Fieldsite"	before students begin work
"Building a Relationship: The One-to-One Model" "Building Skills and Self-Esteem"	when students start work
"Making Room in the Family" "Making Room in the Culture" "Additional Help and Information"	later in students' work

Special Times for Using *No Two Alike*

When students use "Ways of Learning about Children" in *Getting Involved,* they might adapt the exercises to prepare for work with children with special needs.

When they use "Helping Skills," they can apply the problem-solving and team-building techniques to work at fieldsites with children with special needs.

When they consider *Doing Things,* the Fieldsite Previews in *Getting Involved,* or view course films, they might consider how the situations would be different or the same if they involved children with special needs.

When they use *A Child's Eye View,* they can apply what they learn about how children view others to their work with children with special needs.

If Time Is Limited

If you have only limited time to use *No Two Alike,* students might first skim the anecdotal material in the booklets. You might choose to use only a few sections of the book, such as: "Raising Some of the Issues," one or two relevant case studies in "Meeting the Children," "Building a Relationship," and "Building Skills and Self-Esteem."

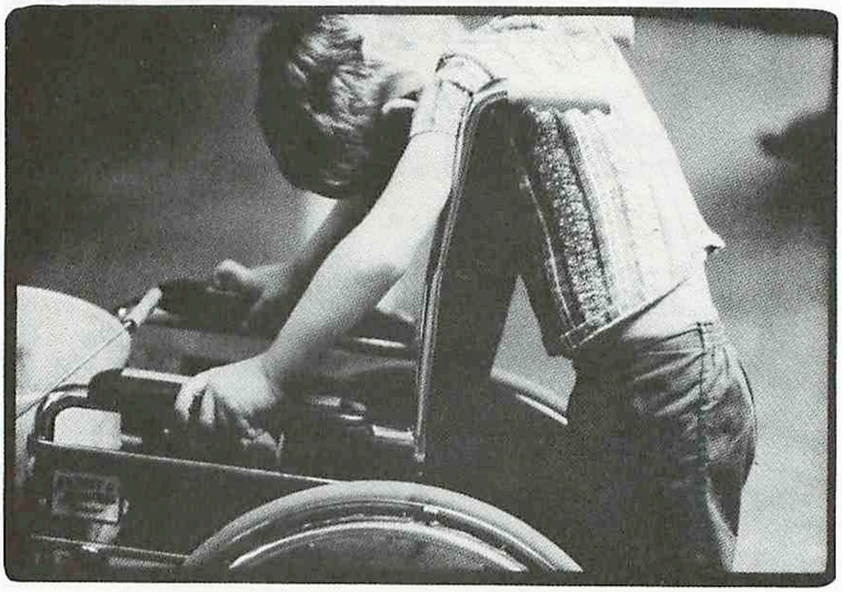
If Time Allows

If you have extended time to use *No Two Alike,* many activities suggested in the student booklet can be expanded.

If students have collected news items related to children with special needs, they might debate issues raised by the articles, talk to people in the community for more information, or invite speakers to class.

Students can extend what they learn from a case study about a special need by doing research, reading first-person accounts, and inviting speakers to class.

Using *The Inquirer* guidelines on doing research and sharing information, students can explore the community resources listed on page 50 (in this guide) and share what they have learned with people in the school and in the community.



Henry Felt

Raising Some of the Issues

What Do We Mean by "Special Needs"?

Children with special needs are those who are often called "handicapped." Some of these children have poor vision or hearing. Others have crippling conditions and must wear leg braces in order to walk. Still others require special attention in learning to speak, read, or play with other children. To call these children handicapped implies that they cannot do certain things, and that their growth must ultimately be limited. In describing a child as handicapped, the emphasis is not on his or her *potential* for growth, but on his or her disability.

What does the term "handicapped" suggest to you? To find out, try the exercises below with other members of your class.

Word Association

> Write the word "handicapped" at the top of a sheet of paper. Give yourself five minutes to put down all the words (pictures and ideas) that come to mind in connection with the word. Then compare notes with your classmates. What words or ideas come up most frequently?
>
> Can you recall the first time you heard a person described as "handicapped"? Who was that person? What was your impression of him or her? Do you think it was a fair one?

Raising Some of The Issues

Purposes:	To consider what it means to have special needs. To prepare students for work with children with special needs through observation and consideration of their own feelings and expectations.
Time:	3-4 classes.
Materials:	*No Two Alike*, pp. 2-12; *Getting Involved*, pp. 12-14.

What Do We Mean by "Special Needs"?

One way for students to understand and grow with their successes and failures in working with young children is to discuss and confront as openly as possible the feelings they have about the children and the situations in which they work. In working with children with "special needs" the process is no different.

Before discussing students' feelings about children with special needs, the teacher may need to consider carefully how deeply the students wish to go into the topic.

> Are there any adolescents with special needs in the classroom?
>
> Does someone in the class have a close relative or friend who has a special need?

If you or any student has personal experience with special needs, you can act as resources in planning class discussions or in clarifying issues during discussion, if you are comfortable with this role. Discussions should emphasize the issue of special needs rather than particular personalities, and should focus on the *strengths* of individuals with special needs.

Word Association

To compare students' word associations to the term "handicapped," you might write responses on the chalk board. Then ask students to develop a few categories under which the words could be classified. Some possible categories might be:

Perception (Visible fact)	Misconception (Something I later found was untrue)

OR

What I know.	What I need to know.

From their categories, students can discuss whether the connotations of the words are positive or negative. Students might also formulate statements about their individual perceptions, based on the information now on the chalk board.

Students can describe any experiences they might have had with people who have been termed "handicapped." In describing the person's handicap, students should try to recall their own reactions to the person and to the experience.

> What were your initial reactions? Why?
>
> In reflecting on the experience, do you feel that your actions or words were inappropriate? Explain.

Photo Exercise

In the second exercise, students are presented with a photo of a child with dental braces, a condition that might be labeled a "handicap" because of the subject's poor self-image, others' perceptions of the subject, unwarranted prejudice toward the subject, or a variety of other factors. The idea here is that the notion of "handicap" involves a confusing mixture of attitudes and feelings about a person's attributes, whereas "special needs" focuses merely on what a person *needs* to manage in a particular situation or to get along in the world. Students might look for other photographs and think of other examples of conditions that may or may not be handicaps, depending on the situation and others' attitudes.

Lilly and Glenda

The entire class should read both the Lilly and the Glenda stories. These two anecdotes offer students an opportunity to look at awareness and expectations as related to special needs.

The Hazards of Labeling

Lilly's story is an example of the development of one's self-esteem. It also is an example of the expectations of others: those of her mother, her employer, and the customers who come to the produce market. Students should consider the concept of self-esteem an important aspect of their work with children with special needs. When working with special needs, it is important that students be aware of, and emphasize, *what that individual is able to do.*

The questions after the reading give students an opportunity to reflect on their preconceptions and misconceptions.

EXAMINING YOUR OWN FEELINGS

Glenda's first experience working at a nursery for children with special needs shows that a first step in being able to help someone who makes you feel uncomfortable is to deal with your own feelings first.

As a class, discuss the following questions:

> Is the way you feel about yourself reflected in the way you react to others? How?
>
> Is the way someone feels about you reflected in the way you react to others? How?
>
> Is it important to measure your own "self-esteem" before you can help others develop theirs? Explain.

Observing at the Fieldsite

Isabel

Isabel's experience in her first grade class provides an opportunity for students to look at labeling and the inappropriateness of jumping to conclusions with only fragmented evidence.

Isabel's need was to communicate with someone. Since she spoke more Spanish than English, some knowledge of her language would have been one way of beginning to meet her needs. This experience demonstrates that being with a child for several hours during the school day does not necessarily provide one with the expertise or information for diagnosing a need. Isabel's teacher had a misconception about Isabel's need, based on generalizations about Isabel's behavior as a member of the class, not on focused observations of her individual behavior.

Training to Observe

In arranging for students to observe at various fieldsites, you may find that not everyone can go to a site that has children with special needs. Those students who do visit such a site can share their observation experience with the entire class, so that everyone shares in a range of fieldsite experiences.

During the visit, students might not want to take many notes. Instead, they can observe the site with questions in mind, as suggested in the observing section of *Getting*

Involved (p. 12). Afterward, students should talk with the teacher or other school personnel who can describe the goals of the particular program, and answer any questions that students might have. Students who are considering working at a site with an "integrated program" should be reminded that the placement is a "team decision," involving student, fieldsite teacher, and course teacher.

Once students know the goals of the program, and after they have observed all the ways in which children's needs are provided for (physically, emotionally, academically, socially, etc.), they will have a good picture of the relationship between *understanding* children's needs and *providing for* children's needs.

Rogier Gregoire

Meeting the Children:

Seven Case Histories

Sara Sibley

You have already met Sara Sibley in the film. You have seen a part of her life as it is today, in the midst of a large, loving family.

But every family has to adjust to a new baby, and the Sibleys were no exception.

Sara was born at 4 P.M. At 6 P.M. the pediatrician came into Mrs. Sibley's room and said, "The baby is healthy and strong, but she's a Mongoloid. . . ."

Mrs. Sibley did not know what "Mongolism" meant. Since she had not yet seen Sara herself, she did not know what to expect. She had not known that mothers over 35 are a bit more likely to have a child with Down's Syndrome, and was shocked by the doctor's casual reference to it. When she talks about that experience today, Mrs. Sibley says that if she had known about the possibility of having a child with Down's Syndrome, she would have had genetic counseling and testing done.

When Sara was born, the hospital staff wanted to hide her from public view. They

Making Room for the Child with Special Needs

Purpose:	To consider what adaptations must be made in a school, a family, or a culture to make room for children with special needs.
Time:	6-7 classes.
Materials:	*No Two Alike*, pp. 13-43; *Getting Involved; A Child's Eye View;* filmstrip, "Children with Special Needs Go to School" (7 minutes); film, "Sara Has Down's Syndrome" (17 minutes); newspapers, magazines, and a scrapbook.
Plan Ahead:	In order to have many students do the large sections of reading in this section ("Model Communities," "Reference Scrapbook," and "Two Mothers"), have them begin taking the books home, reading during free periods, and passing books on to other students as quickly as possible.

Making Room in the Fieldsite

At some time every child in a school temporarily needs special attention or consideration. For the child with special needs, more attention may be called for, and the adjustments may need to be more extensive.

USING *GETTING INVOLVED*

As teenagers work through the materials in the booklet, *No Two Alike*, it would be helpful to refer often to *Getting Involved*. Students will become involved with "special" children as they would with any children: looking for avenues of communication, finding ways to support their work and play, learning how to handle difficult situations.

Students might scan *Getting Involved*, pick out one or more of the situations described, and suggest ways of handling the incident if a handicapped child were involved. Or small groups of students could each choose one activity and brainstorm an adaptation for a particular special need. Students should give reasons for the changes they have made.

BENJAMIN

Ask one student to read aloud the brief case study about Benjamin, the boy who is allergic to chocolate (*No Two Alike*, p. 13). As the class discusses what the solution could have been, refer to "Analyzing Problems and Dealing with Them" (pp. 48-54 of *Getting Involved*). The discussion may also help the students to start considering how people with special needs feel about themselves. The first reaction of many students might be to wish they had planned vanilla cookies; on second thought, they might realize that the incident would provide them with an opportunity to say to Benjamin that they know his limitation with regard to food, but that they also know he is capable of participating in the preparation, even if tasting would not be possible.

An allergy to chocolate is not a severe limitation in Benjamin's life; but how would students feel about talking to a blind child about his or her blindness? Do they think that people with special needs prefer to have their problems ignored? Or do they prefer to talk about them when problems come up? Remind students that people with special needs are individuals, and will not all react in the same way.

The Proper Ratio

The questions in "The Proper Ratio" (p. 13) offer students an opportunity to enumerate the number of children with special needs in their fieldsites, to discuss with their fieldsite teachers why this particular balance has been achieved, and to think about whether the needs of these children are met.

> Are there activities planned that are suitable for all?

Have one student read the case of Jim, the blind student, to the rest of the class. Discuss Ms. Albright's statement that it was probably a mistake for Jim to come to a school for the sighted. Do students agree or disagree? (Refer students to p. 23 of the Reference Scrapbook.)

> What special facilities are there at schools for the blind that Jim might be giving up in going to a public high school?
>
> What are the benefits to be gained from the public school? from the special school?

Students can list facilities at their own fieldsites and discuss their pros and cons in terms of the needs that have to be met.

Children with Special Needs Go to School

On this tape, a number of adolescents share their reactions to working with children with special needs and describe some of the skills they have found useful. The tape might be shown first before students begin working with special needs children, or after they have begun their work. It provides an opportunity for students to discuss their expectations or reactions to special needs children, to reflect about skills that are valuable, and also to learn from other students' comments.

As they watch, students might list in two columns the "joys" students mention ("feel good about helping...kids achieve something"; "something winning about the children") and the "difficulties" ("depressing," "don't like to look at them").

DISCUSSION AFTER VIEWING

How do these emotions compare with those of class members? Have class members' expectations or reactions been influenced at all by the tape? Explain. (For example, students on tape say such things as "You learn to take braces and other aids for granted...." "You learn not to feel sorry for them....")

Lastly, students might list and discuss all the skills mentioned that might help them work with special needs children (being patient; helping children help themselves; letting them express feelings or get into trouble; developing one-to-one relationships; etc.).

Imaginary Companions

This exercise asks students to explore ways to meet the special needs of imaginary children in their fieldsite. (Any experience students have had should be kept in mind as they consider appropriate adaptations in fieldsite environments.) Students will have to plan space and materials, and decide what changes are needed. If students are working in a fieldsite where different kinds of needs are evident, they might talk specifically about how that site is arranged--or could be arranged--to accommodate those special needs.

If students have not yet started going to their fieldsites, "Imaginary Companions" might be postponed, or special visits for small groups of students might be arranged with schools in your area.

In doing the exercise, it is helpful for students to imagine that they are invisible, but at the special child's elbow, following him or her throughout the day. Students may need to look ahead to the glossary to find out what sorts of things might prove troublesome to their particular child.

Reactions of Classmates

Ask students to supply stories of children's reactions to people with "special" appearances. If any of your students have have experiences at a pediatric ward of a hospital, at the fieldsite, or on the streets, they probably are aware that children have their own way of perceiving others, and will not necessarily focus on the same things that an adult will. Students can refer to the booklet *A Child's Eye View* for examples and explanations of children's special way of viewing the world.

Predicting Reactions

When students are asked to imagine how children would treat a child with a special need, they should think of children whom they know. The discussion will probably result in a wide range of predicted reactions, most of which are possible. This is really the point: no two small children will react to new classmates the same way, because each takes his or her own egocentric view of the newcomer (refer students to *A Child's Eye View*). The person who is working with such a class must be prepared to deal with each individual reaction in the process of acclimating the new pupil. Students might also draw up a list of possible adult responses to the children's reactions they have already predicted.

Making Room in the Family

Students who work with children with special needs must acquire an appreciation of the considerations that face the families of these children.

Sara Has Down's Syndrome

Show the film "Sara Has Down's Syndrome" (17 minutes), and allow students plenty of time to express their reactions to it. (Transcript starts on p. 46 of this guide.) For some, it may be their first encounter with Down's Syndrome; for others, it may demonstrate capabilities in a child they might have categorized as being capable of doing little or nothing. Students might take notes on two lists:

Abilities Sara has	Special care Sara needs
in market, puts cans on check-out counter	needs to be told "no" many times (in market, about feeding dogs, at cellar door)
spreads own sandwich	needs help with dressing
cleans up spills	her pace is slower
plays with blocks	needs questions and instructions repeated many times
vacuums	
says words	

Where is Sara in her development? (Look for proof of her mother's comment that how retarded or how old she is depends on the activity.) What has she learned? What is she still learning to do? (Talk, dress.) Students might observe the various teaching techniques used at Sara's school. (Sara is rewarded with food and praise; taught words by repetition, mimicking, and acting out--e.g., moving her arm "up" as she says "up.")

Students may relate to the teenage siblings in Sara's family, and want to talk about how they think they would feel if Sara were in their family. For example, Sara's sister says that, since Sara is seven, she is old enough to understand right and wrong, and should be punished when she does something wrong. Do students agree? Sara's brother was once embarrassed by Sara, but now enjoys helping her learn. How would students feel in a similar situation?

Students may wish to discuss Sara's relationship with her parents, and how they themselves would feel as parents of such a child. What personal qualities enable this mother and father to make room for Sara in their family? Mrs. Sibley says that Sara has brought her family closer together because of a special problem. How might this come about? What other effects might a special child have on a family? Some students may wish to talk about people with special needs in their own families.

Family Comments

After students have read the "Family Comments" on making room for special children, they should discuss the questions on page 18. It might be well to direct the discussion toward a consideration of both the welfare of the child and his or her family. Ask students to list and discuss in small groups the kinds of decisions that face the family of a child with special needs, and the points in the child's life when these decisions must be made.

Making Room in the Culture

Model Communities

The articles on pages 19-20 describe two special communities where groups of people live productive lives despite, in one case, retardation, and in the other case, advanced age. Students might discuss in small groups or write about aspects of each community that made it possible for these people to lead such productive lives. If time allows, students might begin an inquiry into what attitudes and facilities exist in their own (or other) communities for giving those with special needs (e.g., old age or mental retardation) a chance to lead the fullest possible life.

Tracking Down Community Resources

The kinds of issues raised in this section might suggest possible topics to students doing their *Inquirer* projects (see *The Inquirer*, and *Family and Society, Part One, Teacher's Guide*, pp. 71-75). It might be well to mention early in the year that students will each be given a chance to do such a project, so that they can be looking for a topic that interests them. This section need not be considered essential work for those classes that have little time to work on *No Two Alike*.

If your students started a scrapbook early in the year, or if they begin one now, they might be able to compare the kinds of clippings they have collected with the selection in the student booklet. The articles in the Reference Scrapbook cover a wide range of opinions about the best way to serve people with special needs--as seen in legal provisions, public facilities, and in people's own personal decisions. They are included to serve as a model for putting together a scrapbook.

Students might also debate or write "position papers" about the issues raised by the articles and invite relevant speakers to class. Students should use these articles as leads, to start more complete research so that a single view will not predominate.

Two Mothers

The two readings about children with Down's Syndrome should be read by every student, if possible. The handling of the two cases was radically different, and should point out to students that two sets of intelligent, responsible, and loving parents can make different types of decisions for their children. If students consider what they might have done in a similar situation, they should be careful not to judge the behavior of the parents they have read about. Their decisions were clearly influenced by the advice given them by the professionals available to them, and by the facilities that existed in their own communities. Students should consider in depth what resources in the culture and in the community affected the parents' decisions.

> How did the advice these parents received make them feel?
>
> What help would you want in this situation?
>
> How can a community serve people making decisions about caring for children with special needs?

The reports are both very moving. Allow time for students to comment on their feelings about the behavior of these parents, and to compare their behavior with that of Sara's parents in the film, with an eye toward discovering what behavior is common to all caregivers of children with special needs.

Royer Gregoire

Making Room for the Child with Special Needs

Making Room in the Fieldsite

Every child needs special consideration in preschool or kindergarten at one time or another. The child just recovering from a long illness, the child who has had to cope with the appearance of a new baby at home, the child who is frightened of thunderstorms—each may be unable to work within the usual structure and routines of his or her classroom on a given day, or for a certain period of time.

Take Benjamin, for example. Benjamin is allergic to chocolate. Last week his class made brownies. Jessica, the student in charge of the activity, had forgotten about Benjamin's allergy and had not thought ahead about whether or not to include him in the project. She hoped that perhaps he might get absorbed in painting or block building, but when she set up the table for cooking, there was Benjamin, ready and waiting.

What was Jessica to do?

What would you have done?

The Proper Ratio

Making room for a child may call for relatively minor adjustments in schedule, staffing, or environment. It may also call for a highly individual-

Meeting the Children

Purpose:	To present first-person accounts of parents and children who have experienced special needs, in order to give students insight into the unique experiences of individuals.
Time:	Up to 9 classes.
Materials:	*No Two Alike*, pp. 43-60.

The following case studies are included in "Meeting the Children":

- Sara Sibley (Down's Syndrome)
- Jeffy Conrad (hyperkinesis)
- Diana Feinstein (blindness)
- Roberto Martinez (deafness)
- Ned Becker (dyslexia)
- Charlie O'Neill (emotional problem)
- Elise Brown (cerebral palsy)

The children presented in the case studies are not meant to be considered a representative sample of all children with the particular diagnosis cited. Each child is one individual with a special need.

Appendix IV of this guide (p. 68) includes medical descriptions of each case to help you begin planning ahead for related activities and projects.

Plans for considering the case studies might include:

- projects that students may wish to do to gather additional information about one of the conditions mentioned.
- fieldtrips to places where students can observe children with special needs similar to those presented in the case studies. You may not always be able to locate a site with a special-needs case similar to one presented in this section, but observing any need and the way in which the fieldsite meets it can give students a point of reference for further discussions.
- inviting a resource person to visit the class. Students would have to research the type of resource person they are interested in, and how they would go about contacting the person. They will also need to decide how the classroom visit would be conducted--as a lecture, discussion, etc. Resource people could include the parent of a child with special needs, a pediatrician, a social worker, a case worker who is involved with a child receiving therapy, a preschool teacher who has a child with special needs in the classroom, the tutor of a child with special needs, a physical therapist, a representative from a residence that provides for children with special needs (e.g., home, school, health facility), a representative from a research facility like the March of Dimes.

If time is a problem, you might assign each case study to a particular group of students, who will then report on the case study in class, and be the resource people for a classroom discussion. If you group the case studies in the order in which you will deal with them in the classroom, the first group of students should be given all the booklets to prepare for the class assignment. Those students who are not involved in the reading assignment may begin to do research on the conditions mentioned in the case studies and/or collect material for the scrapbook.

If you plan to have a resource person visit the class to talk about a particular special need, it may be important to have all the students read the related case study material prior to the visit. If the case studies are assigned as homework, remind students to consider the questions on p. 60 as they read the cases.

Using the Glossary

Before reading and discussing the case studies, or when terms come up in class, students should consult the glossary (p. 86, *No Two Alike*) to become familiar with the terms used for diagnosing children with special needs. These short definitions, combined with the case studies, should give students a good idea of both the strengths and needs of the children they have read about. A medical dictionary is another source that the students may consult. The bibliography (p. 83, *No Two Alike*), can be a starting point for students who will be collecting additional information on various aspects of special needs raised in the case studies. You can supplement the student bibliography with information from this guide: "Bibliography" (Appendix III, p. 56), and "Background Information" (Appendix IV, p. 68).

Discussing the Case Studies

The following questions might help you organize a discussion of the case studies. Ask students to jot down the issues that seem to occur over and over in each story. Then, as a class, consider:

> What were some of the experiences that the parents had at the birth of these youngsters? Are there any similarities in the experiences?
>
> What roles did the hospitals and/or pediatricians play?
>
> In what ways have these children been learning and growing? What are some of the school experiences of these children?
>
> What kinds of changes have been made in the lives of the families to accommodate these children?
>
> Are the issues any different than they would be for children without special needs?

THEMES IN THE CASE STUDIES

There are several underlying themes in the case studies that have not been dealt with in the student booklet, some of which will be presented here. These themes may facilitate discussion or give rise to additional information on the issues involved:

- diagnosis
- developmental patterns
- medication
- confidentiality of records
- therapeutic techniques
- genetic counseling
- parental involvement
- moral and ethical issues

Each theme is considered in the light of a quotation from a corresponding case study, though many or all of these themes may be noted in each case study. If students select other statements from the case studies that correspond to the themes, they will be noting the similarity and differences among the needs expressed in the cases. The questions on page 25 of this guide may facilitate class discussion; in addition, explanations of some of these issues are given in the appendix.

Diagnosis: Jeffy (see p. 69, Appendix IV)

Some doctors think hyperactivity might be caused by damage to the part of the brain that controls nerve impulses. Other experts ascribe the condition to the fact that children everywhere are born with different temperaments, and have different ways of responding to the world.

There are other viewpoints on the cause of hyperkinesis besides the two stated in Jeffy's case study (p. 44). What is more important to consider, however, is how to *help* a hyperactive child. There are children who are simply unable to stay with one activity or to sit still for even a short period of time. It is important for students to consider how to meet the needs of such children, both in terms of parenting and in terms of working with young children.

1. Are Jeffy's needs physical, emotional, or both? How would having Jeffy's problems diagnosed as physical or emotional make a difference in how his parents treat him? his teachers? How would it make a difference in how his parents feel about him? about themselves?

2. How would knowing the way in which Jeffy's mother provides for his needs help you in planning your work

with Jeffy? What qualities in the mother's behavior help her to deal with Jeffy's behavior? How could you follow her example in handling Jeffy at storytime in school?

3. What generalizations would you make about the qualities that are necessary for anyone working with children like Jeffy?

Developmental Patterns: Sara (see p. 43)

"Of course, as she grew we could see the differences between Sara's rate of development and our other children's, but after a while you stop comparing Sara to other children and just look at her for herself and all the wonderful things she can do."

All children have individual rates of growth. For this reason, it is very difficult to draw comparisons between different children's growth. Two children of exactly the same age may excel in different developmental areas. There are, however, some expectations that one can have about the ability of children with special needs to perform in specific areas of development.

1. Sara's parents expected a slow developmental process in their daughter, because she was diagnosed at birth as having Down's Syndrome. The Sibleys were realistic about what they could expect of her. Compare this with the Beckers' expectations of Ned. What caused their expectations?

2. Consider the "Directions in Development" poster (*Looking at Development*, Module II) in light of Sara's special need. In which areas would developmental progress be slower?

Medication: Jeffy (see p. 45)

"The doctor gave us some medication for Jeffy when he started nursery school. The teacher there recommended that we get some. Actually, she said that if we didn't get something for Jeffy, she wasn't going to accept him."

The use of medication to control hyperactivity is a controversial subject among experts. You may want to discuss what medication does for a child like Jeffy, and how it might be harmful or helpful.

In terms of Jeffy's needs:

> What do you think about the doctor's recommendation? What do you think of the teacher's recommendation? What would you personally recommend? On what do you base your opinion?
>
> Is it necessary for every child in a nursery school to operate under the same behavioral code? Explain. Can a variety of behavior codes exist together in one setting? How? Are both individual and group needs met by having one behavior code? Explain.

Confidentiality of Records: The Seven Children

It is essential that students who work with children with special needs know about the diagnoses and recommend treatments for these children. On the other hand, children and their families have the right to decide what is known about them and by whom. You may wish to discuss the conflict between the confidentiality of records and the need to know certain information in order to meet children's needs.

> Who should know confidential information and why?
>
> How should one treat confidential information?

Therapeutic Techniques: Ned (see p. 53)

[Ned] had trouble keeping numbers in the proper columns when doing arithmetic, but he was not permitted to use special graph paper to "organize" his addition for him. And no one would allow him to take tests orally, instead of on paper. The school didn't want to make a "special case" out of Ned.

While Ned's parents and his first-grade teacher drew on skills Ned was good at (e.g., speech and touch), subsequent teachers did not believe in adapting their procedures for Ned.

Students might like to do some research--or simply discuss their own beliefs--on the best methods for teaching children with special needs.

> Do they believe that children with special needs should be rewarded for successful behavior? punished for mistakes? Why?
>
> Do they believe that such children should be given special activities, or be asked to do what other children are doing? Why?

<u>Genetic Counseling: Roberto</u> (see p. 50)

"Roberto's baby sister Maria was tested along with him, and we were told that she was also deaf, though only moderately. The kind of deafness our children have is hereditary. That's why it's so important to get genetic counseling."

The Martinezes were unaware of factors in their genes that could cause the birth defect of deafness. Mrs. Sibley did not know the statistics concerning Down's Syndrome in the children of "old-age" mothers. If they and the other parents had known in advance about the possibility of such an occurrence, they might have had genetic testing done, been able to prepare themselves psychologically for the birth, or had time to learn about the particular needs that the offspring might have. You might read the following excerpt about birth defects to students and ask them to consider:

> What kinds of considerations should parents make in deciding whether or not to have a child?
>
> What help can they get in making this decision?

Students should consider that a decision about whether or not to have a child depends not only on the medical information one might receive from a doctor, but also on a parent's religious or moral beliefs about one's right to interrupt a pregnancy.

Early Diagnosis of Birth Defects*

A woman can now be tested early in her pregnancy for an increasing number of inherited disorders in order to determine whether or not the child will be affected by them.

The disorders that can be diagnosed in early pregnancy are 1) virtually all chromosomal abnormalities (such as Down's Syndrome--formerly called "mongolism"); 2) certain biochemical diseases (that is, some amino-acid disorders); and 3) sex-linked diseases, carried by females, but affecting males (hemophilia, muscular dystrophy).

These diagnoses can be made by studying the amniotic fluid and the cells in it which are from the fetus. About two tablespoons of amniotic fluid (the water surrounding the fetus) [are] withdrawn from the uterus by the procedure called amniocentesis.

Amniocentesis should be done between fourteen and sixteen weeks of pregnancy. There's a one percent risk of losing the baby if you choose this procedure early in pregnancy. Later the risk is greater. It generally takes about fourteen to eighteen days to do most of the laboratory work to make a prenatal diagnosis.

Who might want to have this done? (1) Mothers who have already had a child with one of certain hereditary biochemical diseases. (2) Women who are carriers of serious disorders that affect males only. (3) A mother who has had a child with a chromosomal abnormality and who may wish to have the test done because of increased risk or because she is anxious during this second pregnancy. (4) Sometimes women over forty who get pregnant, since the risk of having a child with a chromosomal abnormality increases as the woman gets older.

The amniocentesis can be done in a doctor's office either by your own obstetrician or an obstetrician connected with a prenatal genetics team.

Parents who are carriers of certain hereditary diseases can be diagnosed before the woman becomes pregnant by studying a blood or skin sample.

---

*From *Our Bodies, Ourselves*, by the Boston Women's Health Book Collective. New York: Simon and Schuster, 1971.

If you find that there might be a chance of your fetus having birth defects, it will be your decision, along with the advice of your physician, as to whether or not you will continue your pregnancy. One doctor suggests that if you would continue your pregnancy in either case, it would be wiser to omit the test.

The preceding excerpt refers only to a physician's advice in cases of possible birth defects. After reading the article, consider with your students other sources of help for prospective parents: e.g., social workers, religious counselors.

Parental Involvement: Charlie (see p. 3 of guide)

Three more wetting incidents followed the first one. At this point, Mrs. Randolph decided that perhaps she had better schedule a home visit. Usually she waited until October before scheduling parent conferences, but in Charlie's case it seemed advisable to meet with the parents sooner. Mrs. O'Neill seemed relieved when Mrs. Randolph asked if she would be able to come in for a chat, and they made an appointment....

As you discuss the case study of Charlie O'Neill, look at the kind of information that was exchanged between teacher and parent.

> How did this information contribute to a better home-school relationship?
>
> What are the benefits incurred when parents and teachers share similar concerns about a child? How are such positive relationships established?
>
> How can you use the strengths of the home environment in the classroom?
>
> Should students be involved with families? What factors would be important in such a relationship?

Placement Decisions: Diana (see Reference Scrapbook and p. 2 of guide)

Diana came to live at the Parkman School last September. Her parents thought that being in a residential school with other blind and visually impaired children would give her a much *needed "lift." She was accustomed to being the center of attention at home, and at Parkman she would have the chance to be with other children whose needs were just as great as her own. In addition, she would be receiving daily physical therapy for weakened leg muscles, which were a result of cerebral palsy.*

One important and difficult decision for the parents of a "special" child to make is how to provide care for their child. Should the child stay at home, or live in an institution? Should the child be cared for by someone else in the home, or outside of the home? Should the child attend a regular school, or a special school? What considerations should parents make in reaching their decision?

Examine and discuss the considerations made by the Feinsteins in deciding to enroll Diana in the Parkman School.

> What seem to be the benefits of having enrolled her?
>
> Do students discern or anticipate any costs?

Role-Play Activities

Another method of dealing with the case studies is to have students role play situations that involve a person with a special need. (See *Teaching Strategies* for detailed instructions on role playing.) Remind students that this is a serious situation, one that offers them an opportunity to understand the role of the person with special needs and the role of the person who is assisting that individual. Physical needs such as blindness, deafness, and lameness might be the easiest to simulate. Students should realize that they are experiencing a *temporary* need, and that they will only understand the *initial* stages of experiencing and adjusting to a need. Involving the whole class in each activity can help individual students not to feel conspicuous. However, students might also discuss what feeling self-conscious teaches them about the feelings of someone with special needs.

ROLE PLAYING: THE PERSON WITH SPECIAL NEEDS

The class might try one or more of the following role-play activities.

1. Ask students to take turns blindfolding one another. Each student should attempt to go around the room or around another familiar part of the school while blindfolded. Students can work together afterward, listing all the needs that they experienced.

2. Using a pair of crutches, students can take turns attempting to climb stairs, carry books, pass through an aisle of chairs, or do any other physical activity that students might think about.

3. Since total deafness is very rare, students should not attempt to totally block their hearing. They might try reducing by degrees the amount of sound that would be easy to respond to: wearing heavy earmuffs, stuffing their ears with cotton, wearing earplugs. Several students could then try to carry on a conversation with the "deaf" student, varying the noise level and enunciation of their speech.

4. To experience the need for the use of all five fingers, students could tape one thumb to the palm of the hand, then attempt to use that hand "normally."

5. One student might pretend to be mute, then attempt to devise ways of communicating with others in the room. The mute may not speak at any time during the role play.

6. To simulate reading disabilities, students can attempt to read a sentence only by looking in the mirror. The sentence can be within a paragraph in a book, or written on a piece of oak tag. You might try several sentences done in lettering of different sizes.

Afterward, discuss:

> What did you learn from this experience?
>
> What was hard for you? Did you enjoy anything about the experience?
>
> How did people react to you? What help did people give you?
>
> How might your life or habits change if you lived like this permanently?

ROLE PLAYING: THE HELPER OF A PERSON WITH SPECIAL NEEDS

Students may have had a feeling for the needs of a "special" child in the preceding activities; they can now think about what caregiving behavior will best fit those needs.

1. As a group, compile a list of children's emotional needs. All children have emotional needs, but a child with special

needs is particularly vulnerable. This list might include such items as:

> I need to be loved.
>
> I need to be able to trust others.
>
> I need to be provided for as I grow and change, to have new adjustments made to fit my changing needs.
>
> I need to be treated "like everyone else."
>
> I need to be accepted for what I can do--please look at my strengths.

Students can add to the list based on their experience and understanding of special needs.

2. Select a particular special need. Ask for a volunteer to represent a child with that need. (See above suggestions for role playing a person with special needs.) Ask another volunteer to represent a caregiver for the child. The caregiver should state how he or she would respond to the child in different situations, or role play a helper in the situations suggested above. The student representing the child will respond to each statement by the caregiver, explaining how this treatment makes him or her feel. The rest of the class might ask questions to stimulate thinking about areas that the caregiver might overlook, such as, "What would you do at recess time?" or "What new things would you expect to see that child learn to do?"

Afterward, the class and the student representing the child might discuss:

> Was the caregiver being sensitive to all of the needs of the child, emotional as well as physical?
>
> Or was the caregiver overlooking all but the most obvious manifestations of the child's special need?

Building a Relationship: The One-to-One Model

Purpose:	To support students in caregiving relationships with individual children.
Time:	3-4 days.
Materials:	*No Two Alike*, pp. 61-74; *Getting Involved*, pp. 45, 16, 38.

Preparing for Work

This section will be useful reading for students working on a one-to-one basis with *any* children. Students who wish to work in a one-to-one relationship with a child should carefully consider their own motivations, the particular child's needs, and the concerns of the fieldsite teacher.

Some students may find they are more comfortable working with one child than with a group of children. The one-to-one relationship may prove helpful to both the child and the student, but the student must be particularly careful not to let his or her own needs supersede the child's. A student whose motivation is only to help one particular child should beware of encouraging the child to become too dependent on him or her, or of becoming so intensely involved in the relationship that he or she is unrealistic about the process that can be made.

OBSERVING

Children with special needs often need intense individual attention to get them started in participating in activities or relating to others. Students must be careful, however, not to dominate these children, not to make them too dependent on them, and not to hold them back when they are ready to move out of the one-to-one relationship. If students can learn to step back and observe the children they have chosen, they will learn when the children need their help and when they don't.

FIELDSITE TEACHERS AND PARENTS

It is especially important for students interested in a one-to-one basis with a child to work closely with the fieldsite teacher. The teacher should first be consulted about which child the student should work with and about what that relationship might do for that child. Students working with a child with special needs will need to know as much as possible about the child's diagnosis, history, strengths and weaknesses, abilities and disabilities, preferably before work has begun. This information can be shared with students only with the consent of the parents and teacher. For this reason, it is especially important that students discuss the child's needs with the child's parents.

If the specific information cannot be shared with the student, the teacher can help the students by making recommendations about what to do and what not to do. The fieldsite teacher can help students evaluate their progress with a child, and decide what the child is ready to move on to.

FIRST MEETING

To prepare for meeting a child, students might recall "Peter's Goodbye" (field work preview, p. 16, *Getting Involved*), and act out this situation or others they make up or remember. In discussing these role plays, students should consider how they approach new situations and people, how they act and feel, what their strengths and weaknesses are in such situations, and what they would like to change.

Students can also prepare for a helping relationship with a particular child by role playing any of the problem incidents described in "Helping Skills" (p. 38, *Getting Involved*), and getting feedback from classmates on whether or not their behavior might be helpful to a child.

Using the Material

"Building a Relationship" might be used in any one of three ways: by individual students, by the whole class, or by small groups of students.

INDIVIDUAL STUDENTS

Individual students could take turns reading this section as homework, passing the booklets on as they finish with them. Students might be asked to skim the journal entries first, briefly outlining the issues each entry addresses.

If they have not yet begun working with children, students might make a list of their expectations about it in their journals, then compare these expectations with Elise's and Glenda's experiences. Are they similar/dissimilar? Would students feel comfortable/uncomfortable in situations like Elise's and Glenda's? Why?

If students have begun working with a child, how are Elise's and Glenda's experiences like and unlike their own? How do they account for these differences and similarities?

After skimming the journal entries, students could go back and read the section as a whole. As they are reading, they might briefly answer in their journals the three sets of questions: the chart on the student's expectations for working with children (p. 63), the questions on what you do when you feel you have stepped on someone's toes (p. 71), and the questions on how you feel about working with a child whose future development is uncertain (p. 74). Later the class could discuss their answers in small groups.

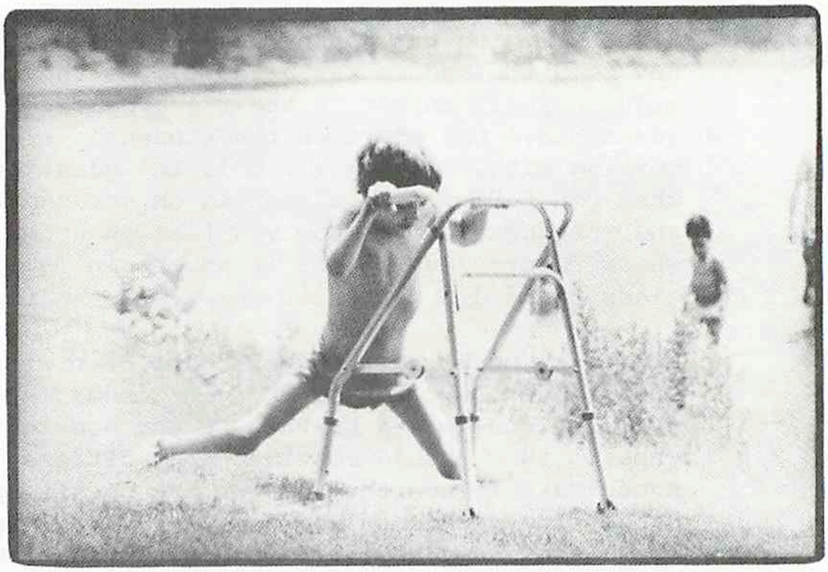
WHOLE CLASS

Students who are working with children with special needs, and students who are not, might discuss the questions about expectations (p. 63 of the student booklet). In their discussion they should consider what difference their experiences make in how they answer the questions. In a class discussion, students who have read "Building a Relationship" could share any new insights on the questions with students who have not read this section.

There are several exercises suggested in this section that can be done by the whole class regardless of whether everyone has read the section or is working with special children. Exercises on expectations for working with children (p. 63), making contact (p. 64), observing to note what a child is capable of doing (p. 67), the "Here-and-Now Wheel" to note feelings (p. 69), and making regular journal lists of what has been learned (p. 72) are important for all students working with children. These exercises could be done periodically by the whole class.

SMALL GROUPS

Students who choose to work with children on a one-to-one basis should be given a chance to talk with each other periodically to share experiences and work on problems together (p. 72). Such meetings might take place while other students working with children of the same age or at the same fieldsite meet to share experiences. Several times during the year these groups might report to the class and compare their experiences.



Henry Felt

Building Skills and Self-Esteem

A Supportive Learning Environment

For any child, learning is easiest in an environment of trust and acceptance. A preschooler likes to know that the teacher is someone who understands private feelings, and who likes people for themselves. The child enjoys the reassurance of a daily greeting, a coat hook with his or her own name or photo, and a birthday cupcake.

A child's self-esteem, like yours, rests heavily on experiences of accomplishment and success. A child with special needs may come to school burdened with a backlog of discouraging or anxiety-causing experiences. Such a child may need much encouragement and support. Children who perceive themselves as having failed often in the past are likely to be reluctant to try new things, but knowing that they are valued for themselves can give them incentive to "try out their wings."

Any good preschool or kindergarten naturally provides enough flexibility and choice so that no child need think of him- or herself as a failure. For the child with special needs, you may need to adapt some learning activities to make them meaningful or effective. Your job is to *help* the child learn to use his or her resources with confidence, and to compensate for the abilities he or she may not have.

Alternative Learning Modes

This exercise should start you thinking about alternative learning modes—ways of adapting learning activities. Suppose

Building Skills and Self-Esteem

Purpose:	To suggest specific teaching methods to use with children with special needs.
Time:	3-4 days.
Materials:	*No Two Alike*, pp. 75-82; *Doing Things; Getting Involved*, p. 8; *Working with Children* (teacher's guide), p. 27.

The suggestions made here shed light on how *all* children learn and can be read by all students, but they are *crucial reading* for students working with children with special needs.

Before beginning the section, students might describe in their journals how they acquired a particular skill, such as guitar playing, ice skating, or speaking a foreign language. They should describe both the physical and emotional stages involved in this learning. Or they might describe orally the steps in a process like tying a bow or changing a tire to someone who does not have that skill. They might also refer to "Trying Out a Child's World" (p. 8, *Getting Involved)* and do this activity as a special child. Such exercises can help students to consider not only the steps involved in learning a skill but also the needs of a child in learning a skill.

Two Exercises

"Alternative Learning Modes" (p. 75) and "Adapting the Approach" (p. 76) could be read aloud in small groups of students. Afterward students might consider how they would adapt many of the activities in *Doing Things* for children with particular special needs (blindness, deafness, poor motor coordination, etc.). They might also look at the list of play areas, equipment, and activities on page 27, *Working with Children* teacher's guide, and consider how each of these might have to be adapted for a child with special needs.

Both "Alternative Learning Modes" and "Adapting the Approach" contain activities that might be done individually, then shared in small group discussion.

Skill-Building Strategy

As students read about the "prescriptive teaching" model, they should apply each suggestion to a situation with a child--a hypothetical situation if they are not yet working with a child, a real situation if they are. They can write a description of how they would help that child acquire a skill.

The emphasis in this strategy is placed on how to help children acquire the self-help skills that lead to self-esteem. But students should also consider how and when to help children learn to play and interact with other children.

> How might your own relationship with a child prepare the child for relationships with others?
>
> How might you make room in a group of playing children for a child with special needs?
>
> When would it not be appropriate to do this?

Additional Help and Information

Purpose: To suggest community and reading resources to students seeking more information about special needs.

Materials: *No Two Alike*, pp. 83-106.

This section should serve as a resource to students who voluntarily choose to seek more information about the children they are working with. The resources of people, places, and readings suggested in the student booklet are supplemented by more complete listings on the following pages of this guide. These lists are excerpted from Day Care Booklet #8: "Serving Children With Special Needs," Office of Child Development, 1972. The booklet can be ordered for $.75 from the U.S. Government Printing Office, Washington, D.C., Stock #1791-0176. It might be a valuable reference book for the class.

In addition to researching information, visiting community agencies, and inviting speakers to a class, students might want to act on the information they acquire (see *The Inquirer*, Guidelines 6 and 7). Some suggested follow-ups for students might be to:

- attend meetings of parent advocacy groups such as the Massachusetts Association for Retarded Children (MARC);
- compile lists of community resources and distribute these to parents;
- present a program on special needs to faculty members and students at your school;
- volunteer your services at agencies such as the March of Dimes, or at medical centers where research is done.

Appendix I: Film Transcripts

Children with Special Needs Go to School

Numbers on this transcript correspond to numbered slides and indicate when to change slides during narration. Every tenth slide has a higher-toned beep.

(1, 2, 3, 4) When you go into the fieldsites (5) or work with kids, one of the things that you have to keep in mind is that you have to sort of slow down (6) into another gear (7). You have to slow down because it takes them longer sometimes to do things (8, 9, 10) and you have to slow down your own pace so they can keep their own speed (11, 12, 13). You have to get with their pace and relax and realize that you have to have some patience (14)....(15). And if you do have patience and you can help the kids achieve something that they really need, (16) then they feel pretty good about themselves and you feel pretty good about yourself if you can help them do that. (17) The first week, every time you'd go into the rooms or when they were playing outdoors just looking at the kids, (18) they were so--I don't like to use the word "ugly"--but you didn't like to look at them (19). I think that the newest thing, (20) something that I don't think anybody's really ready to deal with, that they've never dealt with before--it's having to be in such close proximity and having to deal with people who have physical handicaps (21) and who don't function the way you ordinarily expect to function. And I was freaked out (22). You know, it's like my instincts of sort of giving were sort of stifled (23) by my instincts of revulsion or something completely different.

Sometimes we can get very put off by braces (24) or hearing aids or walkers or things like that, and really they're not (25) much different than eyeglasses; and we can get used to seeing people in eyeglasses (26). And very soon when you work with kids who use an aid of this kind--after a while you don't see it anymore (27). You realize that it isn't important (28). That is true, like any physical disability--when you see braces and, uh, (29) wheelchairs and things like that--and it really upsets you. You get so depressed; I was really depressed (30). And in my journal day after day I'd say, boy--I didn't know what my own feeling was, to tell you the truth.

(31) There's something very winning about children, so that close personal attachment to a child or two--this will pull them through that. (32) After you got to know them you know their abilities--some of them look so helpless, and they seem so helpless, but they're really not. You know (33) I think...that I'd have to know them a little while (34) before I could really start really working with them and not feeling sorry for them (35, 36). When you're talking to them (37) you look directly into their eyes and say it (38)--say it where they know you're talking to them and they have no excuse for getting out of it. (39) If we really take the time out and just look at them (40) and say it slow if it has to be said slow, go ahead and say it that (41) way--but just to let them know that you're going to be

talking (42) to them and that you want them to understand. (43, 44, 45, 46, 47) I always felt when I'd see a special child in the street or something, (48) ah, she must be always mothering him and always helping him and everything --it's taught me that (49) even though they're handicapped they don't need all that--they do need special attention and everything, but (50) give them a little bit of freedom and they can do it; if you just give them a chance they can do it. But I always felt, well, you don't ever let them do that alone because (51) what would they do? And I've really looked at them a lot differently (52). It's like working with a baby (53). You really have to get your cues nonverbally. So (54) you're not just trying to keep her quiet; you're trying to stimulate her (55) and make her more involved in every activity (56). You have to watch what makes her happy, what gives her pleasure, what she responds to (57). And your goal is to keep her as actively involved as possible (58). So you really have to look for every little cue (59).

(60) And I think that's really fantastic--cooking with the children (61). Because I feel that even blind people--they're going to have to do it at one time in their life (62) and if they learn it while they're young it's going to stay with them (63) and they'll get better and better at it, you know....(64).

One of the things that kids with special needs need to do is to get into trouble (65). Most people treat them like they're fragile, or have to be treated especially nicely and are afraid to show their feelings and so on (66). You can't always hold it in. It has to come out sometime. (67) They are human beings whether they're handicapped or not (68) and they have feelings and like anybody else they have to have a chance (69) to express them (70, 71).

(72) One thing that teenagers do bring is sort of a--playful approach (73). When you've been teaching for years as an adult sometimes you forget to play with kids (74), which is one of the most therapeutic things you can do (75). And the teenagers would come in and kind of horse around with the kids or get closer to their level in terms of playing chase games (76) or throwing snowballs or playing hide-and-go-seek (77). You know those kinds of things which sometimes adult teachers forget how to do (78, 79, 80, 81, 82, 83).

Sara Has Down's Syndrome

Mother: *Sara is my youngest child, the youngest of five. She's six and she's retarded. She just doesn't sit as you might think a retarded child would, just doing nothing. She has so much energy. She keeps going and going and going.*

Want to make a sandwich? Hey Sara, do you want to make a sandwich?

Sara: Two.

Mother: Do you want to cut it? Okay.

Sara: Um.

Mother: Okay. Over to the table.

When Sara does things it's just her own speed. You just wait. You can't force things to happen. Whatever pace she's set, is the pace it's going to happen at, whether it's making a peanut butter sandwich or climbing up in the high chair. Whatever she's going to do. It's her own pace and you just have to wait. Sometimes if you just look at her and you enjoy her for the moment, at whatever she's doing, and not try to rush things, you appreciate it a little bit more.

Want juice or milk, Sara. Sara? Do you want juice or milk? Juice? Say juice.

Sara: Duice.

Mother: Okay. No Sara, no. No. Hey Sara, no. Hey, no.

Some of the things that Sara does are negative. But you can't let those negative things defeat you. She keeps trying to do many things and you keep saying no, no, no. But in the process she will learn and she is learning. And you just keep your sense of humor. They're the best fed dogs in the country.

Good girl. Good girl. Don't share them. Don't share with them, no. Sara, eat. More juice? Juice? Hey, Sara, Sara, want more juice? Hmmm? Oh, the table is not that dirty. No, no. Go get a sponge and clean it up then. No, no, no.

Sara's older sister Tabby sometimes is impatient with Sara. She thinks perhaps there should be a little bit more discipline.

Tabby: *When she was first born I reacted, I think, the worst of anyone. As far as I am concerned she should be punished when she does something wrong. She's seven years old and there is no reason, retarded or not, there is no reason why she should get away with throwing a glass of milk across the room. Because she knows it's wrong.*

Mother: Thank you. See that, get Cully's helmet. No, no, no, no.

We're working on speech both at home and they are also working on speech at school. Both the teacher and the high school student who goes down to the school from the high school.

Teacher: Up, down, up, down.

Mother: *I think the school's now decided that in order for Sara to learn speech, she's going to have to say things, particularly in the line of food, before she gets them. And she will respond to food, always.*

Teacher: Can you say soup? See if she'll say soup for you.

Sara: Sooop.

Teacher: Very good. Can you say grapes? Grapes. Sara, grapes.

Mother: *The high school girl will repeat words and Sara will repeat them after her. Now words are coming out.*

Teacher: Grapes. Put it in. Can you say grapes? That's it. Grapes, Sara. Grapes. Grapes.

Sara: Gapes.

Teacher: That's it. Can you say apple? Apple.

Sara: Apple.

Teacher: That's it. Good.

Mother: *Sara went through the beginning stages of speech, the babbling stage, and I thought she was all ready to start talking. But suddenly, she stopped. And I guess this is the way retarded kids go through stages. They begin something and for no reason there's a blank.*

Teacher: No you do, you can do it. Go ahead, put it in right. Go ahead, you can do it. Go ahead, almost. There you go. Yeah. Good girl.

Mother: *Sometimes people ask me how old is Sara? How retarded is she? I answer, "It all depends on what you are talking about." Sara can do many things. She can take out a vacuum cleaner if I'm vacuum cleaning, and plug it in and vacuum the room along with me. All of her own volition. She can make a peanut butter sandwich. She does put her toys away. Now that's an age that's hard to hit. A lot of these things she's learned at home. A lot of these things she's learned at nursery school.*

So it all depends on what you're thinking about, whether she's a three or a five. But we don't push it. Whatever she does, hopefully the next day she'll do a little bit better in whatever area it is.

Martha and Emmy are Sara's next two older sisters. And they really enjoy Sara, either working with her speech or just playing with blocks. They appreciate each little step that she makes. I think there is a real communication between them.

Sister: Don't throw the train down the stairs. Sara.

Brother: Hit her over the head with it.

Sister: Shut up. Sara, stop it. Don't throw it down the stairs. Stop it.

Father: *Just the word "no" is not enough. You have to almost seem emotional when you say the no. Because if she can't see that you are upset, then she won't believe you anyhow.*

Here Sara, put your glass on the table. Put it on the table. That's a good girl.

Mother: *Sara's brother Collee enjoys working with Sara, particularly in speech.*

Collee: Can you say carrot? Say carrot.

Sara: Cassot.

Collee: That's a girl, there you go. Big girl, Sara.

When my mother first had her I was sort of embarrassed to bring her down to the beach but that gradually went away. Then all the kids found out, you know. Most of my friends had seen her and so I'm not embarrassed about her anymore.

Sister: You know what Sara tried to do the other day was cut with scissors.

Collee: Thank you.

Father: She was doing quite well with it.

Collee: Sara, want some cheese? Some cheese.

Sister: Don't put a lot on, Collee, it tastes awful.

Sara: Cheese.

Collee: Great girl, Sara. There you go.

Sister: It tastes awful, when there's a lot.

Collee: It's good when it's a lot.

Sister: I had some meatballs and I put a little too much.

Sister: Want some salad?

Father: A little red from spaghetti. Still red from spaghetti. Here, put it in the water. Go on, put them on. Get your toes stretched out there a little bit. That's a good girl. Okay, pull them up. Pull them up. Pull them up. Come on, pull them up. Come on, pull them up.

Sara: Vrum. Vrum.

Father: Pull them up. Come on, stand up. Okay, pull them up.

You can't be disappointed if she can't catch on right away. But she seems to catch on sooner or later, if you keep at it. And I think that's probably the most important thing, keeping at it.

No, no. You've got the wrong part, young lady. Hey, get a hold of this. Come on, get a hold of it. Come on, get a hold of that. Get a hold of this, up here. Pull it. Pull it. All right, come on. Here you go, put your arm in. Now get your other arm in. Okay, come here. Here, Sara. Come on, get the zipper. Get a hold of it. Get a hold of it--pull it. Pull it up further, go ahead. Pull it up a little bit further, go ahead. That's a big girl.

Mother: *I think Sara has brought my husband and I closer together. We realize the problems of all children, Sara being different from the other children. But the other children are also different from Sara. And I think the whole family is closer together by a special problem of Sara.*

Father: Put your head on the pillow. Come on. Your head, your head, put your head on the pillow. Okay, nitey nite.

Appendix II: Community Resources

This list includes some of the many resources day care programs have discovered in their communities. Valuable resources often go unused simply because people don't think of calling on them. Find out who's doing what in your community and establish working contacts wherever possible. You'll benefit all the children in your program, not just the ones with special needs.

SPECIAL CLINICS AND CLINICIANS

PEDIATRIC CLINICS, PUBLIC HEALTH CLINICS, MATERNAL AND CHILD HEALTH CLINICS, CHILD DEVELOPMENT CLINICS, WELL-BABY CLINICS, NEIGHBORHOOD HEALTH CLINICS, PEDIATRICIANS, PHYSICIANS, PUBLIC HEALTH NURSES CAN:

- identify, evaluate, and diagnose general health conditions of children--physical, muscular, heart-related, neurologically-related, etc.
- identify emotional and learning problems in children
- refer a child with a special problem to a specialist in that area
- provide instruction and counseling for parents
- consult with your staff on health problems of particular children or activities to promote general health of all children
- serve as a referral source to your program

MENTAL HEALTH CENTERS, CHILD GUIDANCE CLINICS CAN:

- identify, evaluate and diagnose emotional problems in children
- identify, evaluate and diagnose learning problems in children
- offer therapy and medication, if necessary

COMMUNITY ACTION AGENCIES, SOCIAL SERVICE AGENCIES, COMMUNITY WELFARE COUNCILS, WELFARE OFFICES, NEIGHBORHOOD CENTERS CAN:

- identify and evaluate children with special problems or refer them to diagnostic clinics
- refer children and families to proper specialists
- offer financial assistance to families or refer them to other sources of financial assistance
- provide funds for day care programs
- offer family counseling services
- offer recreational programs for children
- serve as a referral source for your program

REHABILITATION CENTERS CAN:

- identify, evaluate and diagnose physical and motor problems in children
- provide physical therapy--exercises and

activities to restore gross motor functions and develop necessary muscles for sitting, creeping, walking, etc.
- provide occupational therapy--exercises to develop fine-motor coordination and muscular development for activities such as feeding, dressing, writing, cutting, pasting, etc.
- help fit children for braces, prosthetic devices, crutches, wheelchairs
- provide instruction and counseling for parents
- consult with your staff on problems of particular children or activities to exercise physical and motor development of all children
- refer children from the clinic to your program, if appropriate

SPEECH AND HEARING CLINICS CAN:

- assess a child's hearing
- prescribe hearing aids, if necessary
- identify, evaluate and diagnose speech problems
- offer speech therapy and speech correction
- offer language evaluation and diagnose problems
- provide instruction and counseling for parents
- consult with your staff on problems of particular children or activities to exercise speech and hearing development for all children
- refer children from the clinic to your day care program, if appropriate

VISION CLINICS, OFFICES OF OPTOMETRISTS AND OPHTHALMOLOGISTS CAN:

- assess a child's vision
- diagnose visual learning problems
- prescribe eyeglasses or corrective devices, if necessary
- provide instruction and counseling for parents
- consult with your staff on vision problems of particular children or activities to exercise the visual development of all children
- serve as a referral source to your program

4-C COUNCILS

The 4-C (Community Coordinated Child Care) Councils encourage communities to take a comprehensive, coordinated approach to day care and preschool services. These councils, composed of interested day care and preschool operations, gather information about the community's child care needs and the resources and funds available. Administered by the Office of Child Development, 4-C is organized at the local, State, regional and Federal levels. To find out where your nearest 4-C Council is located, contact the Office of Child Development, Box 1182, Washington, D.C. 20013, or the Office of Child Development at your nearest Federal Regional Office.

UNIVERSITIES AND COLLEGES

SPECIAL EDUCATION DEPARTMENTS CAN:

- place special education students in day care programs to practice teaching
- help identify and evaluate children with special problems
- consult with and/or train your staff to work with special children
- inform you about conferences and training institutes related to special children
- refer your staff to other programs and agencies which work with special children

SCHOOLS OF SOCIAL WORK CAN:

- place social work students in day care programs for field placement--to work with families of children or coordinate community resources for special children
- consult with and/or train your staff in areas of family involvement, family

counseling, coordination of community resources
- refer your staff to other programs and agencies which work with special children

PSYCHOLOGY DEPARTMENTS CAN:

- place psychology students in day care programs for field placement--to identify, evaluate, diagnose and treat special problems, work with families
- consult with and/or train your staff in psychological problems of all children and of special children, ways to identify potential problems in children, how to handle the emotional problems of children and their families, the emotional needs of staff
- refer your staff to other programs and agencies which work with special children

SCHOOLS OF MEDICINE, NURSING, PUBLIC HEALTH, PHYSICAL AND OCCUPATIONAL THERAPY CAN:

- place students for field placement in your program
- consult with and/or train your staff in related areas
- refer your staff to other programs and agencies which work with special children
- offer diagnostic and treatment services

PUBLIC SCHOOL SYSTEMS

TEACHERS OF SPECIAL CLASSES, ITINERANT AND RESOURCE TEACHERS FOR EMOTIONALLY DISTURBED, MENTALLY RETARDED OR PHYSICALLY HANDICAPPED CHILDREN CAN:

- consult with and/or train your staff on the educational needs of special children
- share training programs and any special equipment
- visit and work with special children in your program who may enter their special public school classes

TEACHERS OF REGULAR CLASSES, SCHOOL PSYCHOLOGISTS AND SOCIAL WORKERS CAN:

- visit your program, observe and work with special children who might enter their regular classes

SPECIAL SCHOOLS

SPECIAL SCHOOLS CAN:

- sponsor joint activities for their children and your children on a regular or occasional basis
- consult with and/or train your staff on the needs of special children
- invite your staff to observe special school classes and activities
- refer their children to your program, when appropriate

CIVIC GROUPS

CIVIC GROUPS CAN:

- volunteer for your program--either for group activities or on a one-to-one basis with a child
- donate or build equipment for your program
- contribute or raise funds for your program
- transport children to and from the center
- publicize the program in their newsletters and at their meetings
- lobby for legislation favorable to day care funding and programs

STATE DEPARTMENTS

STATE DEPARTMENTS OF PUBLIC HEALTH, MENTAL HEALTH, MENTAL RETARDATION, WELFARE, REHABILITATION, EDUCATION AND SPECIAL EDUCATION CAN:

- provide funds for day care programs, for special consultants, for staff training, or for supportive services for special children
- offer training and consultation for your staff
- refer your staff to other sources of funding, of program development

ASSOCIATIONS DEALING WITH CHILDREN AND DISABILITIES

Contacts with associations for parents, educators, and professionals are really useful. These associations often have conferences and run training institutes which will be of interest to your staff. Their newsletter can keep you informed of new programs and services in your area, pending day care legislation, funding sources. The national offices of these associations can send you a list of their publications which will be of interest both to teachers and parents. Below are the addresses of some of the national associations for children with disabilities and for general child care:

AGENCIES AND ORGANIZATIONS DEALING WITH EARLY CHILDHOOD AND DAY CARE:

American Association of Elementary-Kindergarten-Nursery Education (EKNE)
NEA
1201 16th Street, N.W.
Washington, D.C. 20036

Association for Childhood Education International (ACEI)
3615 Wisconsin Avenue, N.W.
Washington, D.C. 20016

Black Child Development Institute (Black child development in day care centers)
1028 Connecticut Avenue, N.W., Suite 514
Washington, D.C. 20036

Child Study Association of America
9 E. 98th Street
New York, N.Y. 10028

National Foundation--The March of Dimes
1275 Mamaroneck Avenue, P.O. Box 2000
White Plains, N.Y. 10602

National Multiple Sclerosis Society
257 Park Avenue South
New York, N.Y. 10010

United Cerebral Palsy Associations, Inc.
66 East 34th Street
New York, N.Y. 10016

HANDICAPPED CHILDREN'S EARLY EDUCATION PROGRAM

Dr. Kay King, University of Alabama,
1919 Seventh Avenue South, Birmingham,
Alabama 35233 (205/934-5241)

Dr. Eugenia R. Walker, University of
Alabama, P.O. Box 1982, Tuscaloosa,
Alabama 35489 (205/348-7131)

Dr. Rhoda Wharry, Huntsville Achievement
School, 600 Governors Drive, Huntsville,
Alabama 35801 (205/536-2895)

Dr. Helen Beirne, Alaska Crippled
Children & Adults Treatment Center,
3710 East 20th Avenue, Anchorage,
Alaska 99504 (907/272-0586)

Dr. Elizabeth Sharp, University of
Arizona, Department of Special Education, Tucson, Arizona 85721 (602/
884-3214 or 884-0111)

Miss Louise Phillips, Magnolia Public Schools, P.O. Box 428, Magnolia, Arkansas 71753 (501/234-3511)

Dr. Frank S. Williams, Julia Ann Singer Preschool, Psychiatric Center, 4734 Fountain Avenue, Los Angeles, California 90029 (213/662-2118)

Mrs. Lottie Rosen, Early Growth Center, 1720 Oregon Street, Berkeley, California 94703 (415/644-6183)

Dr. Patrick F. Estes, Los Angeles Unified School District #3, 450 North Grand Avenue, Los Angeles, California 90012 (213/625-8911--Ext. 2784)

Mrs. Judith Sachse, Dubnoff School for Educational Therapy, 10526 Victory Place, North Hollywood, California 91606 (213/877-5678)

Dr. Annabel Teberg, Casa Colina Hospital for Rehabilitative Medicine, 255 East Bonita Avenue, Pomona, California 91767 (714/593-1336)

Dr. Hilde S. Schlesinger, University of California, 401 Parnassus Avenue, San Francisco, California 94122 (415/731-9150)

Dr. Jerome G. Alpiner, University of Denver, Department of Speech Pathology & Audiology, 2065 South York, Denver, Colorado 80201 (303/753-2223)

Dr. Murray Rothman, New Haven Board of Education, 1 State Street, New Haven, Connecticut 06511 (203/562-0151)

Dr. Enid Wolf, Developmental Center for Special Education, 1619 M Street, N.W., Washington, D.C. 20036 (202/737-4864)

Mrs. Natalie Arrington, Federal City College, 733 8th Street, N.W., Washington, D.C. 20001 (202/783-2770)

Dr. Bertrice Cornish, Georgetown University, University Affiliated Center for Child Development, 3800 Reservoir Road, N.W., Washington, D.C. 20007 (202/625-7170)

Mrs. Marcia Shuler, Liberty County School Board, Bristol, Florida 32321 (904/643-3361)

Mr. William J. Kirkpatrick, Jr., Sunland Training Center at Miami, 2000 N.W. 47th Avenue, Opa Locka, Florida 33054 (305/624-9671)

Dr. Mary M. Wood, University of Georgia, 698 North Pope Street, Athens, Georgia 30601 (404/549-8004)

Miss Harriet Bograd, Children's Circle Planning Corporation, 530 East 169th Street, Bronx, New York 10456 (212/588-3452)

Mrs. Ronnie R. Gordon, New York University Medical Center, 400 East 34th Street, New York, New York 10016 (212/679-3200--Ext. 3219)

Mrs. Berta Rafael, United Cerebral Palsy of New York City, Inc., 399 East 44th Street, New York, New York 10017 (212/661-0900)

Mrs. Una A. Haynes, United Cerebral Palsy Associations, Inc., 66 East 34th Street, New York, New York 10016 (212/889-6655)

Mrs. Jeanette Burroughs, National Urban League, 55 East 52nd Street, New York, New York 10022 (212/751-0300--Ext. 237)

Dr. William R. Faucette, City School District, 46 Moran Street, Rochester, New York 14611 (716/464-9368)

Dr. Ann Bardwell, The Ohio State University, 9 West Buttles Avenue, Columbus, Ohio 43215 (614/422-4285)

Dr. Bruce Metzgar, Medford School District #5490, 2801 Memiman Road, Medford, Oregon 97501 (503/779-3520--Ext. 314)

Mr. William H. Thornton, Portland School District #1, 631 N.E. Clackamas Street, Portland, Oregon 97213 (503/777-1769)

Dr. Louise Sandler, The Franklin Institute, 20th & Parkway, Philadelphia, Pennsylvania 19103 (215/488-1508)

Dr. Roger Buchanan, Home for Crippled Children, 1426 Denniston Avenue, Pittsburgh, Pennsylvania 15217 (412/521-8608)

Dr. Peter Hainsworth, Rhode Island Easter Seal Society for Crippled Children & Adults, Inc., 333 Grotto Avenue, Providence, Rhode Island 02906 (401/521-6800)

Dr. Erbert F. Cicenia, South Carolina Department of Mental Retardation, Coastal Center, Jamison Road, Ladson, South Carolina 29456 (803/873-5750--Ext. 365)

Dr. Freeman McConnell, The Bill Wilkerson Hearing & Speech Center, 1114 19th Avenue South, Nashville, Tennessee 37212 (615/383-2420)

Dr. John P. Ora, George Peabody College for Teachers, Child Study Center, P.O. Box 158, Nashville, Tennessee 37203 (615/327-8084)

Dr. Alton D. Quick, Memphis State University, Memphis, Tennessee 38111 (901/321-1771)

Dr. Patricia G. Adkins, Region XIX Educational Service Center, 6501-C Trowbridge, El Paso, Texas 79905 (915/772-5294)

Dr. Tina E. Bangs, Houston Speech & Hearing Center, Texas Medical Center, 1343 Mourisund Avenue, Houston, Texas 77025 (713/524-3136)

Mrs. Otilia V. Vidaurri, Edgewood Independent School District, West Commerce Street, San Antonio, Texas 78237 (512/433-2361)

Mr. Robert DeVoid, Brattleboro Town School District, 96 Green Street, Brattleboro, Vermont 05301 (802/257-7852)

Dr. Ruth Diggs, Norfolk State College, 2401 Corprew Avenue, Norfolk, Virginia 23504 (703/627-4371)

Appendix III: Bibliography

Child Development

Fraiberg, S. *The Magic Years: Understanding and Handling the Problems of Early Childhood*. New York: Charles Scribner's Sons, 1959. A practical book which discusses developmental problems of children from birth to six years.

Gesell, Arnold, et al. *The First Five Years of Life*. New York: Harper and Row, 1940. Discusses developmental stages of children from birth to age five.

Hartley, Ruth E.; Frank, Lawrence K.; Golderson, Robert M. *Understanding Children's Play*. New York: Crowell Collier and Macmillan, Inc., 1957. A general guide to understanding the developmental significance of different forms of children's play.

Hymes, James. *The Child Under Six*. Englewood Cliffs, N.J.: Prentice-Hall, 1963. A simplified version of the development of the child from birth to six years.

Murphy, Lois Barclay. *The Widening World of Childhood*. New York: Basic Books, Inc., 1962.

Mussen, P.; Conger, J.; Kagan, J. *Child Development and Personality*. New York: Harper and Row, 1969. A textbook of child development from birth to adolescence summarizing and integrating research findings.

Von den Eyken, W. *The Pre-School Years*. Middlesex, England: Penguin Books, 1967. A book on understanding children's development and behavior during the preschool years.

Curriculum and Teaching

Ashton-Warner, S. *Teacher*. New York: Bantam Books, 1963. An account of the author's experiences teaching Maori children in a New Zealand Infant School. It gives practical advice about teaching.

Association for Childhood Education International, 3615 Wisconsin Avenue, N.W., Washington, D.C. 20016. Publishes material related to theory, curriculum and methods in early childhood education. Write for a listing.

Bank Street College of Education Publications, 69 Bank Street, New York, N.Y. Publishes material related to most aspects of early childhood education. Write for a listing.

Battin, R.R.; Haug, C.O. *Speech and Language Delay: A Home Tradition Program*. Springfield, Ill.: Charles C. Thomas, 1968. $5.50. Includes information for parents on how language and speech develop, discipline training for children with speech delay, suggestions for an educational program, methods of stimulation and motivation, training the ear, and auditory and visual memory.

Behrmann, Polly; Millman, Joan. *Excel: Experience for Children in Learning.* Cambridge, Mass.: Educators Publishing Service, Inc., 1968. A good collection of simple activities to promote oral expression, visual discrimination, auditory discrimination, and motor coordination in preschool children. It emphasizes family-oriented activities, but is also useful in the classroom.

Brown, Carolyn. *For Beginning-to-Be Teachers of Beginning-to-Be Students.* Nashville, Tenn.: Demonstration and Research College for Early Education, George Peabody College for Teachers, 1971. $1.50. A simple and practical guide for teachers just starting to teach preschool children. It includes materials about child development, curriculum and working with parents.

Camp, Janet; Wilkerson, Peggy. *All About Me.* Nashville, Tenn.: The Demonstration and Research College for Early Education, George Peabody College for Teachers, 1971. $1.50. A curriculum guide to help preschool children understand and accept themselves and others.

Carmichael, Viola S. *Curriculum Ideas for Young Children.* Los Angeles, Calif.: Southern California Association for the Education of Young Children, 1971. Curriculum ideas for young children, mainly in the social science and science areas. For copies send $3.00 to Mrs. Carmichael, 1886 Kenneloa Canyon Road, Pasadena, Calif. 91107.

Cohen, Dorothy H.; Stern, Virginia. *Observing and Recording the Behavior of Young Children.* New York: Teachers College Press, Columbia University, 1969. A book on the evaluation of the growth of individual children.

Cooper, Georgia; Hatch, Betty; King, Peggy. *Wings Emerging: Language Opportunities and the Pre-School Child.* Pleasant Hill, Calif.: Contra Costa County Department of Education, 1966. A guide to promoting language development of preschool children through many types of activities.

Department of Elementary, Kindergarten, Nursery Education, National Education Association, 1201 16th Street, N.W., Washington, D.C. 20036. Publishes material relevant to early childhood education. Write for listings.

Dittmann, Laura L., ed. *Curriculum Is What Happens: Planning Is the Key.* Washington, D.C.: National Association for the Education of Young Children, 1970. $1.75. A series of short articles dealing with planning and evaluating day-to-day experiences in programs for young children.

Education Development Center, 55 Chapel Street, Newton, Mass. 02160. Publications on making equipment from free or inexpensive materials and on curriculum. Write for listing.

Engel, Rose. *Language Motivating Experiences for Young Children.* Van Nuys, Calif.: Don Figge Associates, 1968. $4.95. Lesson plans and experiences in language development in specific curriculum areas: art, cooking, motor activities, sensory experiences.

Evans, E. Belle; Shub, Beth; Weinstein, Marlene. *Day Care.* Boston: Beacon Press, 1971. $6.95. A book of practical advice on every aspect of planning, developing, and operating a day care center.

Hymes, James. *Teaching the Child Under Six.* Columbus, Ohio: Charles E. Merrill Publishing Co., 1968. A general, practical approach to early childhood education.

Karnes, Merle B. *Helping Young Children Develop Language Skills: A Book of Activities.* Arlington, Va.: The Council for Exceptional Children, 1968. $3.50. A book of activities for teachers to help preschool children develop skills related to all aspects of language development.

Mallum, Mary Alice. *California Children's Centers Curriculum Guide: Goals and Growth Experiences for the Early Years.* Hawthorne, Calif.: Children's Centers Directors and Supervisors Associations, 4568 West 133rd Street, 1970. A helpful guide to setting and carrying out goals in the various curriculum areas.

Murphy, Lois; Leeper, Ethel. *Caring for Children Series.* Washington, D.C.: U.S. Department of Health, Education and Welfare, Office of Child Development, Bureau of Head Start and Child Service Programs, 1970.

Number One: The Ways Children Learn. A practical, easy-to-read pamphlet which tells how children learn, what they need to know and how the teacher can help them learn.

Number Two: More Than a Teacher. A pamphlet which tells how day care workers contribute to the child's development by giving him or her love and understanding as well as teaching.

Number Three: Preparing for Change. Practical advice on how to help a child prepare for new and sometimes disturbing situations in his or her life.

Number Four: Away From Bedlam. Practical advice on finding the causes of and prevention of bedlam in the child care center.

National Association for the Education of Young Children (NAEYC), 1834 Connecticut Avenue, N.W., Washington, D.C. 20009. Publishes a journal and many materials relevant to early childhood education. Write for a listing.

Pines, M. *Revolution in Learning: The Years From Birth to Six.* New York: Harper and Row, 1966. Current theories and practices in early childhood education.

Pitcher, Evelyn Goodenough; Lasher, Miriam G.; Feinburg, Sylvia; Hammond, Nancy. *Helping Young Children Learn.* Columbus, Ohio: Charles E. Merrill Publishing Co., 1966. $3.95. A good curriculum resource for teachers working with preschool children. It presents an orientation to teaching as well as practical suggestions in the various curriculum areas.

Warner, Dianne; Quill, Jeanne. *Beautiful Junk.* Washington, D.C.: Project Head Start, Office of Child Development, 1969. A list of sources of free or inexpensive materials for early childhood programs and suggestions about how to use them.

Wylie, Joanne. *A Creative Guide for Pre-School Teachers.* Western Publishing Company, 1969. A comprehensive guide to goals, activities and materials for an organized preschool program.

Children's Books

Books about differences between children:

Beim, Jerrold. *The Smallest Boy in the Class.* New York: William Morrow and Co., Inc., 1951. Stature isn't always measured in feet and inches.

Green, Mary M. *Is It Hard? Is It Easy?* New York: Wm. R. Scott, Inc., 1960. A boy and girl discover that different things are hard and easy for each.

Krasilousky, Phyllis. *The Very Tall Little Girl.* New York: Doubleday and Company, 1969. A reassuring book about a child who is taller than her friends.

Books about getting along with other children:

Cohen, Miriam. *Will I Have a Friend?* New York: Macmillan and Company, 1967. Jim's fears about not having a friend in his new school disappear as the day progresses.

Carle, Eric. *Do You Want to Be My Friend?* New York: Crowell Collier and Macmillan, Inc., 1971. A child looks for and finds a friend.

Zolotow, Charlotte. *My Friend John.* New York: Harper and Row, 1968. A book about best friends.

Zolotow, Charlotte. *The Quarrelling Book.* New York: Harper and Row, 1963. Friends can quarrel, too.

Night fears and sleeping problems:

Alexander, Anne. *Noise in the Night.* Chicago: Rand McNally and Co., 1960. A light-sleeping reader can find reassurance in this book that tells of things that go bump in the night.

Brown, Margaret W. *Goodnight Moon* (1947) and *A Child's Goodnight Book* (1950). New York: Harper and Row. Two good books to make going to bed easier.

Hoban, Russell. *Bedtime for Frances.* New York: Harper and Row, 1960. Frances, the raccoon, doesn't want to go to sleep. She gradually gets over her fears.

Sendak, Maurice. *Where the Wild Things Are.* New York: Harper and Row, 1963. A young boy conquers terrible monsters.

Family worries:

Brown, Margaret W. *The Runaway Bunny.* New York: W. R. Scott, 1950. A good book for children with separation problems: a mother reassures her child that she will always be with him.

Hoban, Russell. *A Baby Sister for Frances.* New York: Harper and Row, 1964. Frances, the raccoon, is jealous of the new baby sister but learns to like her.

Langstaff, Nancy. *A Tiny Baby for You.* New York: Harcourt, Brace and World, 1955. Real photographs and text show what a new baby is like.

Sickness:

Rey, M. *Curious George Goes to the Hospital.* Boston: Houghton Mifflin Co., 1966. A child's fears about going to the hospital will be relieved as he reads about Curious George, the monkey, and his experiences there.

Guiding Behavior

Becker, Wesley. *Parents Are Teachers: A Child Management Program.* Champaign, Ill.: Research Press Company, 1971. $3.75. Describes the use of reinforcers and punishers in managing children's behavior.

Madsen, Charles H.; Madsen, Clifford K. *Teaching and Discipline: Behavioral Principles Towards a Positive Approach.* Boston: Allyn and Bacon, Inc. Designed to help teachers use behavior principles such as rewarding positive behavior as a part of the teaching method.

Patterson, Gerald R.; Gullion, Elizabeth. *Living With Children: New Methods for Parents and Teachers.* Champaign, Ill.: Research Press Company, 1971. $3.00. Written in the form of programmed instructions, this book introduces the concept of positive reinforcement.

Valette, R.E. *Modifying Children's Behavior: A Guide for Parents and Professionals*. Palo Alto, Calif.: Fearon Publishers, 1969. Presents information for parents on behavior and behavior modification for use in self-instruction, parent counseling, parent education, or teacher in-service training.

Children with Special Needs

Barbe, Walter. *The Exceptional Child*. New York: The Center for Applied Research in Education, Inc., 1963. A textbook describing the different types of special children and their educational needs.

Dunn, Lloyd, ed. *Exceptional Children in the Schools*. New York: Holt, Rinehart and Winston, Inc., 1963. $11.00. Discusses the educational needs of school-age children with special problems. Excellent bibliographies at the end of each chapter on relevant books, resource organizations and films.

Exceptional Children, Vol. 37, No. 9, May 1971. The Council for Exceptional Children, 1411 South Jefferson Davis Highway, Suite 900, Arlington, Va. 22202. This journal, issued monthly, is an excellent informative source on special children. This particular issue is devoted to "The Exceptional Child's Early Years." In addition to many articles on exemplary preschool programs, it contains a directory of resources on early childhood education which lists and describes model preschool programs, agencies and organizations concerned with early education and major publications with interest in the education of young children.

The Exceptional Parent Magazine: Practical Guidance for the Parents of Exceptional Children. Boston: Psy-Ed. Corporation. A new magazine that will be of interest to anyone concerned with special children. It deals with special problems from the parents' point of view, provides technical information stripped of professional jargon and practical advice on day-to-day care. Published 6 times a year; subscriptions are $2.00 a copy; $12.00 a year. Write the Psy-Ed. Corporation, 264 Beacon Street, Boston, Mass. 02116.

Feeding the Child With a Handicap. Health Services and Mental Health Administration, Maternal and Child Health Service. Washington, D.C.: U.S. Government Printing Office, 1967. $.30. This pamphlet provides many helpful suggestions to the parents of a handicapped child who has feeding problems.

Kough, Jack; De Haan, Robert. *Identifying Children with Special Needs*. Science Research Associates, Inc. A book to help identify children in the classroom with potential special needs. Lists observable characteristics of children with hearing and visual problems, physical disabilities, speech problems, learning and emotional problems.

Kvaraceus, W.C.; Hayes, E.N. *If Your Child Is Handicapped*. Boston: Porter Sargent, Publisher, 1969. $7.95. A collection of highly personal accounts by parents of the experience in having a handicapped child.

Murphy, Lois B.; Leeper, Ethel M. *The Vulnerable Child*. No. 5 from the series, *Caring for Children*. Washington, D.C.: U.S. Department of Health, Education and Welfare, Office of Child Development, Bureau of Head Start and Child Service Programs. An excellent, down-to-earth booklet about children in day care centers who may have special problems or vulnerabilities--physical handicaps, emotional vulnerabilities, everyday fears, stresses. Directed to staff in child care centers and homes.

Siegel, Ernest. *Special Education in the Regular Classroom*. New York: John Day Company, 1969. Offers hints for teachers on helping school-age children with special needs to overcome poor self-concept, anxiety, poor coordination, behavioral problems. Many parts of the book are applicable to the preschool child as well.

Spock, Benjamin; Lerrigo, Marion. *Caring for Your Disabled Child*. New York: The Macmillan Co., 1965. $4.95. (Also in paperback, Collier-Macmillan Publishers, $1.95.) A reference book for parents on caring for their disabled children: suggestions about medical care, education, home management.

Weatherby, Doris. *Project Quest: Films on Early Childhood and Special Education*. Pitman, N.J.: Education Improvement Center, South Jersey Region, P.O. Box 426, 08071. An annotated film catalog on early childhood and special education films. Ratings of films on child development, programming, management, environment, special education.

Mentally Retarded Children

Bensberg, Gerald. *Teaching the Mentally Retarded--A Handbook for Ward Personnel*. Atlanta, Ga.: Southern Regional Education Board, 130 Sixth Street, N.W., 30313, 1965. $3.00. An excellent manual for parents and teachers as well as ward personnel. It presents principles and methods for teaching the mentally retarded the various skills and information required for them to be as independent as possible--language development, self-care, etc.

Carlson, Bernice; Ginglend, David. *Play Activities for the Retarded Child*. New York: Abington Press, 1961. $4.00. Ideas for parents and teachers to help the mentally retarded grow and learn through music, games, handicrafts and other play activities.

Connor, Frances P.; Talbot, Mabel E. *An Experimental Curriculum for Young Mentally Retarded Children*. New York: Bureau of Publication, Teachers College, Columbia University, 1964. A curriculum developed for preschool mentally retarded children with sequences of goals set up in the following areas: intellectual development; imagination and creative expression; social, emotional, manipulative, motor, and self-help development.

Dittmann, Laura L. *The Mentally Retarded Child at Home--A Manual for Parents*. Children's Bureau Publication No. 374, Department of Health, Education, and Welfare. Washington, D.C.: U.S. Government Printing Office, 1959. $.35. This parent manual has many suggestions day care staff will also find helpful. It discusses toilet training, dressing, cleanliness, speech, play, etc., from infancy to adolescence.

Doorly, Ruth K. *Our Jimmy*. Arlington, Tex.: National Association for Retarded Children, 1967. $3.95. A book for preschoolers who share in the responsibility of helping a retarded brother or sister. It explains what retardation is and what it means in the life of a family.

Dybwad, Gunnar. *The Mentally Handicapped Child Under Five*. Arlington, Tex.: National Association for Retarded Children, 1969. Describes the different types of services needed by mentally retarded preschoolers and their families.

Environmental Criteria: Mental Retardation Pre-School Day Care Facilities. College Station, Tex.: Research Center, College of Architecture and Environmental Design, Texas A & M University, 1971. Describes the environmental implications of day care programs for mentally retarded, culturally deprived and normal children. Also discusses basic planning considerations in designing activity areas of day care centers, the use of light, color, acoustics, space, etc. It will be most useful for those planning future day care centers; not as helpful (but of interest) to those centers already established.

Ginglend, D.R.; Stiles, Winifred E. *Music Activities for Retarded Children--A Handbook for Teachers and Parents*. Nashville, Tenn.: Abington Press, 1965. $3.50. Designed to help you start a developmental beginning music program for mentally retarded or young normal children.

Gorham, Kathryn. *Selected Reading Suggestions for Parents of Mentally Retarded Children*. U.S. Department of Health, Education, and Welfare, Office of Child Development. Washington, D.C.: U.S. Government Printing Office, 1970. $.60. An excellent annotated bibliography on mental retardation for parents. Includes books and personal accounts by parents; books about families of the retarded; books for siblings of the retarded; manuals on helping the retarded child at home.

McIntire, Pamela. "The Let's Talk Program," *Welfare Reporter*, July, 1971. Outlines speech and language stimulation activities for the mentally retarded. For copies write to: Public Information Office, Department of Institutions and Agencies, 135 West Hanover Street, Trenton, N.J. 08625.

Roberts, Nancy. *David*. Richmond, Va.: John Knox Press, 1968. $4.50. Pictures and text tell the story of the arrival, acceptance and early childhood of the Roberts' mentally retarded son.

Teach Me Now. Norfolk, Va.: Tidewater Association for Retarded Children. $2.00. A guide for teachers of preschool mentally retarded children with suggestions for teaching, learning and readiness skills, for curriculum development, planning and evaluation.

Van Witsen, Betty. *Perceptual Training Activities Handbook*. New York: Teachers College Press, Teachers College, Columbia University, 1967. $1.75. Activities for children with learning disabilities to develop vision, auditory perception and other forms of sensory perception.

Children with Learning Disabilities

Cruickshank, W.M. *The Brain-Injured Child in Home, School and Community*. Syracuse, N.Y.: Syracuse University Press, 1967. $6.50. Written for parents, teachers and others who work daily with brain-injured children. Includes considerations of the symptoms of brain damage, recommendations for diagnostic procedures and personnel, and descriptions of treatment techniques that have proven effective at home and in the classroom.

Ebersole, Marylou; Kephart, Newell C.; Ebersole, James. *Steps to Achievement for the Slow Learner in the Classroom*. Columbus, Ohio: Charles E. Merrill, 1968. Describes the characteristics of the brain-damaged child, enables the teacher to identify the slow learner early, and shows how to develop and sharpen his or her readiness skills.

Flowers, Ann M. *Helping the Child with a Learning Disability: Suggestions for Parents*. Danville, Ill.: Interstate Printers and Publishers, Inc., 1969. $.30. Written for parents of children with learning disabilities, this booklet provides information on the nature of learning and suggests activities parents may use to help children become more aware of their environment and to stimulate their learning.

Golick, Margaret. *A Parent's Guide to Learning Problems.* Montreal 252, Quebec: Quebec Association for Children with Learning Disabilities, 6338 Victoria Avenue, 1970. $1.00. Useful for both parents and teachers, this guide discusses how to help the child with learning problems assume responsibility. The learning process is described and learning activities are suggested which can be carried out in the kitchen and elsewhere in the home.

Golick, Margaret. *She Thought I Was Dumb But I Told Her I Had a Learning Disability.* Montreal 252, Quebec: Quebec Association for Children with Learning Disabilities, 1971. $1.00. Provides an overview of learning disabilities, describing some problem areas for children with learning disabilities and guidelines for evaluating development. Contains suggestions for helping the child in the classroom and at home.

Hart, Hane; Jones, Beverly. *Where's Hannah? A Handbook for Parents and Teachers of Children with Learning Disorders.* New York: Hart Publishing Company, 1968. $8.50. A mother and a teacher relate the experiences of Hannah, a brain-injured 11 1/2-year-old girl.

Kronic, Doreen. *They, Too, Can Succeed: A Practical Guide for Parents of Learning Disabled Children.* San Rafael, Calif.: 1969. $3.75. Written for parents of children with learning disabilities, this text offers practical hints for the solution of recurring educational, physical and social problems.

Learning Disabilities: A Handbook for Parents and Teachers. Des Moines, Iowa: Polk County Board of Education, 112-116 Eleventh Street, 1970. $1.50. A short booklet describing children with learning disabilities and their needs. Contains chapters entitled, "How Can I Help As a Teacher?" and "How Can I Help As a Parent?"

Lewis, Richard S. *The Other Child.* New York: Grune and Stratton, 1960. $3.75. Written for both parents and professional workers, this text in nontechnical language defines and discusses the brain-injured child.

Minde, K. *A Parent's Guide to Hyperactivity in Children.* Montreal 252, Quebec: Quebec Association for Children with Learning Disabilities, 1971. $1.00. Discusses the causes and effects of hyperactivity in children, how parents can help the hyperactive child, different methods of management and possible problems arising during a day with a hyperactive child.

Murphy, John R. *Listening, Language and Learning Disabilities: A Guide for Parents and Teachers.* Cambridge, Mass.: Educators Publishing Service, 1970. $2.00. Describes the characteristics of children with learning disabilities and possible causes of the problems. Includes suggestions on developing listening abilities, speech and language.

Van Witsen, Betty. *Perceptual Training Activities Handbook.* New York: Teachers College Press, Teachers College, Columbia University, 1967. Activities for children with learning disabilities to develop visual and auditory perception and other forms of sensory perception.

Children with Emotional Problems

Axline, Virginia M. *Dibs: In Search of Self.* Boston: Houghton Mifflin Company, 1964. The case history of a young boy with emotional problems as he is helped through psychotherapy.

Axline, Virginia M. *Play Therapy.* New York: Ballantine Books, 1969. A very readable book about a method of therapy for young children.

Baruch, Dorothy W. *One Little Boy*. New York: Dell Publishing Co., Inc., 1964. A boy with emotional problems is helped through therapy.

Bettelheim, B. *Love Is Not Enough*. Glencoe, Ill.: The Free Press, 1967. A book about a therapeutic setting for children with emotional problems.

Braun, S.; Lasher, M. *Preparing Teachers to Work with Disturbed Pre-Schoolers*. Boston: Nimrod Press, Inc., 1970. A report of a training program on teaching teachers to work with preschool children with emotional problems. For copies write to the authors at the Department of Child Study, Tufts University, Medford, Mass. 02155.

Caplan, Gerald. *Emotional Problems of Early Childhood*. New York: Basic Books, 1955. A book about the different kinds of emotional problems of young children.

Joseph, Harry; Zern, Gordon. *The Emotional Problems of Children: A Guide for Parents*. New York: Crown Publishers, 1954. A broad summary of the management of many types of emotional problems in children and adolescents.

Leibman, Samuel, M.D. *Emotional Problems of Childhood*. Philadelphia: J. A. Lippincott Company, 1958. A broad summary of the management of many types of emotional problems in children and adolescents.

Moustakas, Clark. *Psychotherapy with Children--The Living Relationship*. New York: Harper and Row, 1959. On helping children with emotional problems through therapy.

Pavenstedt, Eleanor. *The Drifters*. Boston: Little, Brown and Co., 1967. About the emotional problems of children from low-income families.

Redl, Fritz. *Children Who Hate*. Glencoe, Ill.: The Free Press, 1951. A book about children with emotional problems who seem to hate others; how they got that way.

Redl, Fritz; Wineman, David. *Controls From Within*. Glencoe, Ill.: The Free Press, 1952. A book about helping children with emotional problems to develop their own controls.

Rubin, Theodore I. *Jordi*. New York: The Macmillan Company, 1960. About a child who doesn't relate well to people.

Socially and Emotionally Disturbed Children: A Guide for Parents. Harrisburg, Pa.: Pennsylvania Department of Education, Bureau of Special Education, 1970. A booklet on helping parents understand and find help for their children with emotional problems.

Children with Physical Disabilities

Calovini, Gloria. *The Principal Looks at Classes for the Physically Handicapped*. Washington, D.C.: The Council for Exceptional Children, NEA, 1201 16th Street, N.W., 1969. $1.75. Addressed to the principal who has little or no background in special education, but who has a class for the physically handicapped in his school. This introduction to physical handicaps, their implications and appropriate programs will be helpful to any person interested in the care of physically disabled children.

Dorward, Barbara. *Teaching Aids and Toys for Handicapped Children*. Washington, D.C.: The Council for Exceptional Children, 1960. $1.75. Describes how to make and use a number of teaching aids and toys for cerebral palsied children of nursery school and kindergarten age. The toys have also been used with brain-injured, mentally retarded and multiple-handicapped children.

Finnie, Nancie. *Handling the Young Cerebral Palsied Child at Home*. New York: E.P. Dutton and Co., 1968. $3.50. An excellent guide for parents, nurses, therapists and others involved in caring for young cerebral palsied children. Hints on carrying, bathing, toilet training, dressing, feeding, playing. Contains a list of addresses of suppliers of accessories and equipment, chairs, feeding and drinking utensils, strollers, toys, etc.

Frantzen, June. *Toys, the Tools of Children*. Chicago: National Society for Crippled Children and Adults, 2123 West Ogden Avenue, 60612, 1957. $1.00. Analysis of toys and their use with normal children and in the training and treatment of the physically disabled. Useful as a selection guide for parents, teachers, therapists, physicians and others concerned with children's growth and development.

Helsel, Elsie; Messner, Sherwood; Reid. L. Leon. *Opening New Doors to the Cerebral Palsied Through Day Care and Development Centers*. New York: United Cerebral Palsy Associations, Inc. A booklet discussing the administration, program, staff and parent services in day care programs for cerebral palsied children.

Please Help Us Help Ourselves. Indianapolis, Ind.: United Cerebral Palsy Association of Central Indiana, Inc., 615 Alabama Street, 46204. $2.00. This manual contains directions for constructing easily made, inexpensive adaptive equipment for the physically disabled child--cardboard tables and chairs, styrofoam sit-up table boxes, handles for utensils and games, bicycle pedals, etc.

Blind and Visually-Impaired Children

Dorward, Barbara; Barraga, Natalie. *Teaching Aids for Blind and Visually Limited Children*. New York: American Foundation for the Blind, 1968. $2.75. Presents educational aids specifically designed to develop the physical and mental capabilities of blind children, while bearing in mind their visual limitations. Each educational aid comes with instructions and a list of necessary materials.

Halliday, Carol. *The Visually-Impaired Child: Growth, Learning, Development, Infancy to School Age*. Louisville, Ky.: American Printing House for the Blind, 1971. $3.25. An excellent practical manual for parents and teachers on the care, training and instruction of the visually-impaired child from birth until entry into a formal school program. It describes the basic needs a visually-impaired child shares with all children and presents in outline form how all children normally develop. It lists and describes educational materials and practical techniques to help the visually-impaired child at each stage of development.

Krebs, Mrs. Gordon. *The Blind Child in Kindergarten*. New York: Commission for the Blind, New York State Department of Social Welfare, 270 Broadway, Booklet No. 202. A kindergarten teacher tells of her experience with two blind children in her regular classroom. Discusses parent cooperation, acceptance by other children, adaptations of the program.

Moor, Pauline M. *A Blind Child, Too, Can Go to Nursery School*. New York: American Foundation for the Blind, Pre-School Series No. 1, 1962. $.25. An excellent pamphlet describing the integration of blind children into regular nursery school programs. It discusses the questions raised by nursery school teachers about enrolling blind children; how to introduce the child to the school; what to expect of a blind child in terms of participation in activities and performance; how to prepare the other children for a blind child in class.

Pelone, Anthony. *Helping the Visually Handicapped Child in a Regular Class.* New York: Teachers College Press, Teachers College, Columbia University, 1957. $2.25. Describes the needs of children with visual problems in regular classrooms; the roles of various school personnel (nurse, teacher, counselor, psychologist) in meeting these needs; curriculum adaptations for the regular classroom setting. It deals with school-age children only.

Pfeiffer, Elsbeth. *Study of Joe--A Blind Child in a Sighted Group.* New York: Bank Street College of Education, 69 Bank Street, 10014, 1958. An excellent pamphlet written by a teacher about Joe, a blind child who entered her regular nursery school program. Describes in detail the daily activities Joe could join in and how staff were able to adapt their program to meet his needs.

Toys for Early Development of the Young Blind Child: A Guide for Parents. Springfield, Ill.: The Office of the Superintendent of Public Instruction, 1971. A list of toys to help the blind child in his early development. Toys are categorized according to purpose and age of the child from infancy to age three.

Children with Hearing and Language Problems

Adler, Irving and Ruth. *Your Ears.* New York: The John Day Company. $2.68. Easy-to-read information on the ear and hearing.

Bloom, Freddy. *Our Deaf Children.* London, Melbourne, Toronto: William Heinemann Ltd., 1963. $3.70. The British mother of a severely hard-of-hearing little girl describes the problems a family faces in dealing with a young deaf girl.

Directory of Services for the Deaf in the United States. American Annals of the Deaf, Gallaudet College, Washington, D.C. 20002. A comprehensive listing of schools, clinics, instructional materials, conferences, agencies, and organizations for the deaf.

Harris, Grace M. *For Parents of Very Young Deaf Children.* Washington, D.C.: Alexander Graham Bell Association for the Deaf. $.60.

If You Have a Deaf Child: A Collection of Helpful Hints to Mothers of Deaf Children. Urbana, Ill.: University of Illinois Press, $1.00.

Lassman, Grace Harris. *Language for the Pre-School Deaf Child.* New York: Grune and Stratton, Inc., 1950. $7.45. A teacher of the deaf discusses fundamental concepts, activities and training techniques; also includes a design for nursery school and parent education and selected case histories.

Learning to Talk. Information Office, National Institute of Neurological Diseases and Stroke, National Institutes of Health, Bethesda, Md. 20014, 1969. $.45. This pamphlet discusses speech, hearing and language problems in the preschool child. It also describes normal language development in children from 3 months to 5 years.

Lowell, Edgar L.; Stoner, Marguerite. *Play It by Ear.* Los Angeles: Educational Materials Department, John Tracy Clinic, 806 West Adams Blvd., 90007. $3.50. Auditory training games for young deaf and hard-of-hearing children.

Myklebust, Helmer R. *Your Deaf Child: A Guide for Parents*. Springfield, Ill.: Charles C. Thomas Co., 1950. $4.70. This book describes the kinds of problems confronting parents in caring for the deaf child and ways to meet the child's needs.

Newton, Mary Griffith. *Books for Deaf Children*. Washington, D.C.: Alexander Graham Bell Association. Suggestions of books for nursery school through grade 9.

Palmer, Charles E. *Speech and Hearing Problems: A Guide for Teachers and Parents*. Springfield, Ill.: Charles C. Thomas Co., 1961. An excellent book in question-and-answer format divided into two parts; the first deals with speech problems; the second with hearing problems. Suggestions of what to do and where to go for help.

Ronnei, Eleanor C.; Porter, Joan. *Tim and His Hearing Aid*. Washington, D.C.: Alexander Graham Bell Association. $1.00. A picture book for children who wear hearing aids.

Teach Your Child to Talk: A Parent Handbook. New York: CEBCO, Standard Publishing Co., 1959. $1.50. A reference book for parents of children from infancy to 5 years. Lists stages of normal speech and language development; questions parents can answer to check if their child is developing within normal limits; and suggested games, activities, books, records, etc. useful for speech and language stimulation.

Utley, Jean. *What's Its Name? A Guide to Speech and Hearing Development*. Urbana, Ill.: University of Illinois Press, 1968. A workbook designed for parents and teachers of hearing-impaired children.

The Volta Review. Washington, D.C.: Editorial Office, 1537 35th Street, N.W. A monthly magazine which contains articles for both professional workers and parents. Membership fee is $3.00.

Identifying Special Needs

Sometimes the symptoms of special needs are so subtle that parents may not realize anything is wrong until the child starts failing in school. Then they don't know what the trouble is or how to deal with it.

"Closer Look," a program sponsored by the U.S. Department of Health, Education and Welfare, provides a clearinghouse of information for parents who don't know where to begin to look for help. If you write to CLOSER LOOK, BOX 1492, WASHINGTON, D.C. 20013, you'll get specific advice on how to spot a disability in a child, what to do about schooling, where to find special education programs, job training, financial aid, and parents' organizations.

The service will also provide you with a complete list of all the education officials, special schools, homes, and hospitals treating such children in your state. Upon request, it will also include a list and explanation of your state's laws regarding handicapped children and a listing of your state's vocational schools. In addition you'll get a free subscription to its informative newsletter.

Appendix IV: Background Information

This appendix describes in greater detail seven of the special needs found in the case studies. It is included to provide you and your students with more precise medical information about the causes and treatment of conditions you may encounter in children you work with.

Down's Syndrome*

Definition

A congenital condition characterized by mental deficiency (mental age usually never exceeds eight years); and physical traits such as slanting, widely spaced eyes, flattened nose, small ears, broad hands (often with a single crease across them), and short stature. The condition is caused by an unknown "influence" on the embryo.

Incidence

Down's syndrome afflicts approximately one in 770 newborns in the United States. The syndrome is called "mongolism" because of the appearance of the eyes, but it occurs in all races.

Cause

The most common chromosomal abnormality in Down's syndrome (mongolism) is the occurrence of three number 21 chromosomes rather than only a pair. The total chromosome count is 47

---

*Most of the information in this section is based on a flyer entitled "Chromosome 21 and its Association with Down's Syndrome." Available from The National Foundation/March of Dimes, Box 2000, White Plains, New York 10602.

instead of the normal 46. Failure of the two chromosomes of pair 21 to separate during sperm or egg development produces an abnormal reproductive cell and thus a child with three number 21 chromosomes. This is much more likely to occur in older women. Doctors are now able to detect during pregnancy whether or not the fetus has been affected by Down's syndrome.

Characteristics

The child with Down's syndrome has short limbs and fingers, an enlarged protruding tongue and slanted eyes, often with a fold of skin over the upper eyelid. The facial features and back of the head are flattened. At birth the baby is "floppy" and has weak, soft muscles. Light colored specks in the iris are a common finding, except in dark brown eyes.

MENTAL RETARDATION

This is moderate to severe in most patients, but some can be trained to the eighth grade or an even higher level. It is important to have the child seen regularly by a physician so that he can judge growth and development and aid in making decisions about appropriate education and training.

LEUKEMIA AND HEART DEFECTS

Acute leukemia is 20 times as frequent in children with Down's syndrome as in normal children. About half of all infants with the syndrome have congenital heart defects.

Hyperkinesis or Hyperactivity*

Incidence, Diagnosis, and Symptoms

There are probably five million hyperactive children in the United States. Hyperactivity is the single most common behavioral disorder seen by child psychiatrists. Exact figures are not available, but it seems likely that as many as 5 percent of school-age children have hyperactive problems.

---

*This information is quoted or adapted from *The Hyperactive Child: A Handbook for Parents*, by Paul H. Wender, M.D. (Professor of Psychiatry, College of Medicine, University of Utah). New York: Crown Publishers, Inc., 1973.

Although all children may exhibit the following behaviors at some time to some extent, hyperactive children may have some or most of the following problems in excessive degrees:

1. Hyperactivity or seeming inability to keep still. (Although this is the most common characteristic of hyperactive children, some hyperactive children may actually be normally or less than normally active while displaying many of the other symptoms of hyperactivity.)

2. Attention difficulties: distractability; short attention span; inability to concentrate; inability to listen.

3. Demanding attitude and lack of affectionate behavior: the child seems to want always to be the center of attention; as infants they may not be "cuddly," as children they may be undemonstrative.

4. Impulsivity, or poor impulse control: the child acts without thinking. (Bladder and bowel control may also be related to impulsivity and general lack of self-control.)

5. Perceptual and learning difficulties: although of normal intelligence, their intellectual development is uneven. They may have difficulties distinguishing between similar sights or sounds, directional confusions, memory problems, and language difficulties sometimes associated with the "dyslexic syndrome."

6. Difficulties in coordination: approximately half of all hyperactive children show difficulties in physical (fine and gross) motor coordination.

7. Resistant and domineering social behavior: interpersonal behavior characterized by (1) considerable resistance to social demands (dos and don'ts, shoulds and shouldn'ts); (2) increased independence; (3) domineering behavior with other children.

8. Emotional difficulties (not necessarily psychologically caused): mood swings and unpredictable behavior; under- or over-reactive insensitivity to pain; low frustration tolerance; low self-esteem.

9. Emotional immaturity: the hyperactive child may behave four or five years younger than his or her actual age, though the child is usually intellectually mature.

Causes

It is very important to emphasize first that *most hyperactive children are not brain-damaged.* Hyperactive children are sometimes referred to as brain-damaged because hyperactivity was first described in children who had suffered injuries to the brain. However, many brain-damaged children are not hyperactive, and most hyperactive children are not brain-damaged.

If brain damage is not the cause, what is? There is recent scientific evidence supporting what everyone's grandmother knew: there are inborn temperamental differences among children. What causes these temperamental differences? Child psychiatrists are not certain. A very good possibility is that they are caused by chemical differences in the brain. The brain is an extraordinarily complex interconnection of nerve cells. One nerve cell releases a small amount of certain chemicals, which are picked up by a second cell, causing it to "fire." There are different neurotransmitters in different portions of the brain. If the amount of one neurotransmitter is insufficient, the portion of the brain that it "operates" will not function correctly. Hyperactive children are probably deficient in some neurotransmitters. (In many hyperactive children the quantity of these neurotransmitters probably increases with age. This would seem to be the likely reason that the children improve as they grow older.)

The causes of these presumed chemical differences are again unknown, but there are two general possibilities: (1) anomalies in the development of the baby *before* the time of birth; (2) genetic differences. Little is known about prenatal influences, but there is some possibility that small birth size--and therefore prematurity--may sometimes lead to hyperactive symptoms. Similarly, other variations in the mother's biological processes during pregnancy might result in fetal maldevelopment. With regard to genetic origins, it has long been observed that hyperactive and reading problems sometimes run in families (and among the males usually, when they do). It may be that certain genes control the amounts of neurotransmitters, and that some genes result in too little production of the neurotransmitters. Deficiency in neurotransmitters in this area would result in a decreased ability to focus attention; a decreased ability to check one's behavior--to apply brakes; a decreased sensitivity to others' reactions--to dos and don'ts, and approval or disapproval; and a decreased ability to modulate mood, that is, an increased tendency toward sudden and dramatic mood changes.

Treatment

A very large fraction of hyperactive children can be helped, often to a marked degree, by treatment with medication. Such treatment has stirred up a great deal of controversy, among both parents and doctors. The long-range effects of such treatment is not yet known. In addition, some argue that medication only side-steps the problem, that it is an "artificial" solution. Medication often takes care of only *some* of the problems, leaving others to be resolved.

Those who are "pro-medication" argue that the physician may also suggest psychological treatment for the family and/or the child and/or educational treatment for the child. And medication remains the most widely used form of treatment for hyperkinesis in this country.

All hyperactive children can be benefited by understanding and correct handling. Hyperactive children have special problems, but, like all other children, they may have "unspecial" problems as well. Difficulties, misunderstandings, and friction between parent and child will cause trouble for any child. They may cause more trouble for the hyperactive child.

The hyperactive child does better when he or she is held accountable--made responsible--for his/her behavior. The child should not be allowed to say, either in so many words or indirectly, "I'm hyperactive--I'm a mental cripple--I'm not responsible for what I do." He or she should be treated as a responsible child, and, if necessary, should be told something to this effect: "You do have problems that make it hard for you to control yourself. But the same thing is true for everybody. Everybody does some things more easily than others and does other things with more difficulty. You can learn to count to ten, hold your temper, not tease your sister, and I expect you to."

Some symptoms (e.g., memory, concentration, attention seeking) are far less amenable to psychological and educational treatment than are other symptoms. Some symptoms respond only (if at all) to medication. But proper handling can take care of many problems. In general, hyperactive children should be treated firmly, with consistency and explicitness. Every effort should be made to prevent the child from developing maladaptive behaviors (caused by his or her physical and biological symptoms), which can persist and continue to cause him or her problems long after the symptoms have diminished or even disappeared.

Prognosis

Physicians who have treated hyperactive children over a period of years have repeatedly noted that the problems tend to change, become less severe, and even disappear with age. In many hyperactive children some of the more troublesome symptoms gradually diminish and finally disappear around the time of puberty; in some children such improvements may occur earlier, and in some later. In all hyperactive children some symptoms change and disappear. The hyperactive child may wet the bed longer than the nonhyperactive child, but will not wet the bed forever. Similarly, restlessness and fidgetiness diminish with age. However--and this is extremely important--these symptoms may vanish while other hyperactive symptoms may persist. Difficulty in concentrating, lack of stick-to-itiveness, and impulsivity may remain. The practical consequence is that treatment, when effective, may need to be continued for several years after the most obvious and distressing symptoms have vanished.

Blindness*

Incidence

Because definitions of blindness vary according to countries and/or organizations, it is difficult to determine its precise incidence. The U.S. Committee on the Statistics of the Blind estimated as of 1952 that of every 100,000 people 198 were blind. A minimum world estimate considers six million people to be blind.

Definition and Diagnosis

The United States' definition of blindness as accepted for admission to schools for the blind, rehabilitation benefits, and assistance from social security is as follows: *A person shall be considered blind who has a visual acuity not exceeding 20/200 in the better eye with correcting lenses, or visual acuity greater than 20/200 but with a limitation in the fields of vision such that the widest diameter of the visual fields subtends an angle no greater than 20 degrees.*

A visual acuity of 20/200 means that the eye can distinguish at 20 feet what the normal eye can see at a distance of 200 feet, i.e., the big "E" on the Snellen chart. This definition is limited due to its primary application to distant vision; any short vision and ability to use residual sight should also be considered before labeling a person blind.

---

*Adapted from *The Story of Blindness*, by Gabriel Farrell. Cambridge: Harvard University Press, 1956.

Types of Blindness: Causes and Treatment

Blindness is attributed to accidents, heredity, and disease, whether specific to the eye or not. Damage to the optic nerve or brain can also result in blindness. Even a perfect eye is useless if the ability to transmit or receive and interpret an image is lost.

TRACHOMA

Trachoma has been virtually eliminated in many parts of the world, including the United States, but remains in areas where unhygienic conditions exist. This virus infection causes running eyes and is easily transmitted by direct contact, towels, clothes, and flies. When treated early enough, the loss of sight is prevented. Spontaneous cures are found in 60 percent of trachoma cases.

OPTHALMIA NEOHATORIUM

"Babies' sore eyes" is an inflammation of the conjunctiva. Evident in the first few days following birth, it can be prevented by dropping into each eye soon after birth a 2 percent solution of silver nitrate. The condition has nearly disappeared due to this practice.

RETROLENTA FIBROPLASRA

Usually found three to five weeks after birth in premature babies who weighed less than four pounds at birth. A distortion and overgrowth of the retina's blood vessels leads to detachment of the retina and the formation behind the lens of an opaque mass consisting of the detached retina, blood vessels, and fibrous tissue. The condition ceases its advance in the fourth or fifth month. Thus, initially severe cases may regress so that sight is not ultimately terribly impaired, while mild cases may result in an extreme loss of sight later. The condition has been related to high exposure to oxygen, which is now used more cautiously in the treatment of other ills.

GLAUCOMA

More common in middle-age, glaucoma may also be congenital. It is characterized by bulging and hardening eyeballs. In infants the eye is often removed because of pain or secondary infection. Glaucoma's gradual onset in adults can easily be detected by measuring the pressure in the eye. It cannot be cured, but can be controlled if found in time. Complete blindness results if the condition is left untreated too long.

CATARACTS

Cataracts are most common in the aged, though they may be congenital, due to heredity or the administration of a toxic substance to the pregnant mother. This lens cloudiness may be due to injury, chronic infection, or simple degeneration of the lens fiber with age. Up to a certain point, cataracts can be improved with treatment. Beyond this, the lens can be surgically removed, its function then carried out by glasses or a surgically implanted artificial lens.

BLINDNESS BY DISEASE

Smallpox, tuberculosis, and syphilis may cause blindness. Acquired syphilis is easily cured, and treatment of congenital syphilis can prevent a child's blindness if it is undertaken before the mother's fifth month of pregnancy. A pregnant mother's case of rubella, or German measles, can also cause blindness in the child. The lack or inadequacy of treatment for diabetes may also lead to blindness.

Prognosis

The incidence of visual impairment is low among children in countries having high standards of living, efficient medical care, and good treatment of the sightless. This indicates that much blindness is preventable. On the other hand, good health care increases life expectancy so that the percentage of vision problems due to old age increases. In addition, better medical care allows more imperfect babies to survive. Those with defective sight, if they choose to have children, increase the possibility of the inheritance of visual defects.

Deafness*

Definition

Deafness is found in varying degrees and is of three basic types. *Attenuation deafness*, in which all incoming sound waves lose the same amount of strength, is relatively rare. *Abnormal frequency response* refers to the inability to hear particular frequencies, high or low. (Since English consists mainly of high frequency sounds, the loss of these results in a reduction of the intelligibility of the language to 5 percent.) *Abnormal intensity response* means the inability to hear sounds at certain intensities. Since the

---

*Adapted from *The Deaf and Their Problems*, by Kenneth W. Hodgson. New York: Philosophical Library, 1954.

intensity of sound varies as the square of the distance from its source, hearing is usually aided greatly by decreasing the distance.

Causes

If congenital, deafness may be due to the absence or malformation of part or all of the ear, or malfunction of the brain. Otosclerosis begins in infancy as a progressive deformation in which the oval window membrane, necessary for vibration transmission, becomes bordered and insensitive.

Plugs of wax in the outer ear may press on the tympanic membrane, the "eardrum," and prevent its vibration, but this condition is easily remedied. Head injuries particular to the brain or ear can result in deafness. A puncture of the eardrum, however, will heal in a few weeks, though the new tissue will be coarser. Perforations are dangerous mainly in that they may let bacteria enter the middle ear. The most common cause of deafness is infectious disease.

CATARRHAL OTITIS MEDIA

This is a common result of a congested nose blown too little, necessitating breathing through the mouth. Mouthbreathing disturbs the adenoids and causes their abnormal growth. This blocks the lower end of the Eustachian tube, so that the air pressure on the eardrum is greater on the exterior and the drum caves in a bit. This forces together the bones of the middle ear so that they can no longer vibrate freely. The catarrh also inflames the membranes in this area, further stiffening the ossicles and constricting the Eustachian tube, which aggravates and perpetuates the situation.

SUPPURATIVE OTITIS MEDIA

Also called otorrhoea, this condition may follow catarrhal otitis media or a bacterial or viral infection. Streptococcal infections particularly contribute to this; streptococcus pyogens are often found in the throat of a person who has, for example, tonsillitis, scarlet fever, or influenza. In this instance pus forms in the cavity beyond the eardrum, pressing on the membrane and destroying tissue. Less elastic scar tissue forms and eventually restricts ossicle vibration. The pus may be drained through surgery. If it is not, destruction spreads further. It is possible to save the hearing with surgery at this point, but the situation is critical. Usually such operations are life-saving with deafness an accepted result. Half of these otitis media cases begin in infancy and go undetected.

OTITIS INTERN This occurs when infection spreads to the inner ear and destroys the cochlea's nerve endings responsible for frequency reception. The high frequencies are attacked first, after which the destruction continues down the scale.

AUDITORY NERVE DEAFNESS Mumps, meningitis, or certain drugs used to treat other diseases may cause this form of deafness. It is also common in old age, possibly due to a failing blood supply to the auditory nerve. It is exhibited in a loss of high frequency hearing.

LOUD NOISE Long exposure to loud noise can destroy the part of the basilar membrane holding the nerves corresponding to the frequency concerned. Inability to hear that particular frequency results.

Prognosis

Deafness is often preventable. High standards of living, good medical care, and education can prohibit the spread of the infectious diseases usually responsible. According to loss of particular frequencies and intensities, hearing aids can be tailored to the individual to maximize any remaining hearing. Total deafness must usually remain so, since the ear is formed once in the embryonic child and does not have the ability to regenerate itself.

Dyslexia*

Definition

Dyslexia is defined as a defective capacity for acquiring, at the normal time, a proficiency in reading and writing corresponding to average performance. The deficiency is dependent upon constitutional factors (heredity), is often accompanied by difficulties with other symbols (numbers, musical notation, etc.). It exists in the absence of intellectual defect or of defects of the sense organs that

---

*The material in this section is adapted from *Developmental Dyslexia* by Macdonald Critchley, Senior Neurologist, Kings Hospital, London; Senior Physician, National Hospital, Queen Square, London. London: William Heinemann Medical Books Limited, 1964.

might retard the normal accomplishment of these skills, and in the absence of past or present appreciable inhibitory influences in the internal and external environments.

Incidence

Some experts believe that eight million retarded readers exist in the United States at the present time. It is estimated that about 10 percent of all American children of average intelligence read so badly that their total adjustment is impaired.

Causes and Symptoms

Although the specific causes of dyslexia are unknown, it is generally felt that the condition is neurological in origin. The symptoms of dyslexia result from some specific kind of neurological *malfunction* (not brain damage). Specific or developmental dyslexia has also gone under the name of "congenital word-blindness," indicating both that the disorder is inborn (not acquired) and that it involves problems of perceiving words.

It is also generally acknowledged that dyslexia is to some extent hereditary (especially with males in a family); that it is in some way related (although not causally) to hyperkinesia, mixed dominance, vision abnormalities (especially in visual behavior); and that it has psychological repercussions (similar to those involved in hyperkinesia).

Dyslexia generally refers to the inability to learn to read; however, the syndrome includes a wide span of language and perceptual characteristics that are related to reading on the neurological level. Some dyslexics have problems in speaking, in which verbal/oral symbols are confused and they use wrong words, reverse opposing concepts such as up/down or before/after. Time and spacial concepts are confused in speech as well as in action. In some cases their speech is a jumble of unintelligible sentences and words.

Some dyslexics can learn to read but not to write, or vice versa. In some cases the child can understand when reading to him- or herself, but cannot read the same piece aloud to someone else.

In still other cases, the difficulty includes all sets of written symbols, though some dyslexics excel in math or music (which involve symbols).

Many dyslexics also have problems with motor coordination, rhythm, and memory. And the picture is further confused because a child may have an additional special need, such as hyperkinesia, brain injury, or retardation.

The rate of reading is always considerably reduced in the case of dyslexics, whether they are reading silently or aloud.

READING SYMPTOMS

Various attempts have been made to classify the errors that a dyslexic child makes when reading aloud. Among the principal errors may be mentioned:

1. Inability to pronounce an unfamiliar word, with a tendency to guess wildly at its phonetic structure.
2. A failure to realize the likenesses and differences between words that are somewhat similar in spelling or in sound, e.g., PUG-BUD; ON-NO.
3. A failure to detect, by ear, differences in the sounds of words or letters.
4. Difficulty in keeping the correct place while reading.
5. Particular difficulty in switching accurately from the right-hand extremity of one line of print to the beginning of the next line at the left. This defect has been described as a *linear dyslexia*.
6. Undue vocalizing of sounds while attempting to read silently.
7. Failure to read with sufficient understanding (as checked by such tests as the Monroe Silent Reading Examination).
8. Incorrect pronunciation of vowels, e.g., BAG for BIG.
9. Incorrect pronunciation of consonants, e.g., BOLD for BOLT.
10. Reversals constitute a most important type of error, and may entail mirror-opposite letters (according to the typology employed), e.g., DIP and BID. Or the whole word may be reversed, so that the child reads WAS instead of SAW. Or, again, short sequences of words may be read the wrong way, as in the case of DID HE for HE DID.

11. Phonemes (small units of words) may be interpolated incorrectly, as when the child reads TRICK instead of TICK.

12. Phonemes may be dropped, especially out of clusters of consonants. Thus the child may read TICK instead of TRICK. Or whole syllables may be omitted, as when the child reads WALK for WALKING.

13. An error of quite different type is seen whenever the child substitutes one word for another, e.g., WAS for LIVED. The word suggested may be one which is approximate in meaning, or one that is metonymous (designating some associated notion).

14. Words may be repeated in a persevering fashion, e.g., THE CAT THE CAT.

15. Words--inappropriate or otherwise--may be added, e.g., ONCE UPON A TIME THERE WAS may be read instead of ONCE THERE WAS.

16. One or more words may be omitted altogether, e.g., A DOG instead of A FIERCE DOG.

17. An omission of a different sort is seen in the phenomenon described by the Monroe as a *refusal*. Thus the child, attempting to read ONE OF THE MOST INTERESTING may say ONE OF THE MOST and skip completely over the word INTERESTING.

WRITING SYMPTOMS

An overall untidiness of the penmanship is common in dyslexics, but not universal, for occasionally a dyslexic will write quite neatly, with all the errors conspicuously displayed. Among the characteristic defects in writing the dyslexic may show: malalignment; intrusion of block capitals into the middle of a word; omissions or repetitions of words and letters; rotation of letters; odd punctuation marks; and misspellings. Besides common errors, like those of the habitual bad speller, unusual and even bizarre mistakes are to be found. Typical faults comprise the partial or complete reversals of groups of letters, so that for the word NOT we may find ONT or TNO, or even TON. Another characteristic is an unorthodox manner of joining up adjacent letters. Thus the linkages may be either too long or too short or the strokes may intersect. One letter may fuse with the next to form a strange merger, difficult to identify out of context. This kind of error is spoken of as a *contamination*. Even more typical are the *neographisms*, that is, literal symbols foreign to any accepted system of typology. Another characteristic is the tendency by the word-blind to employ too few letters, either by telescoping words together or by omitting letters.

Treatment

The following are some general principles of treatment used at the Ortblinde Institute (Word-blind Institute) of Copenhagen:

1. The contemporary "look/say" method of reading should be replaced by a more phonic or analytic-synthetic system in the case of dyslexics.
2. The progression from simple tasks to more complex ones should be made slowly and gradually.
3. Visual learning should be reinforced by other sense channels. Thus the dyslexic child should be taught to learn the appearances of a letter (or word); to say the symbol aloud; to trace its outlines digitally; and to write it down.
4. The reading material chosen for learning purposes should be interesting and exciting for the young reader.
5. Toys, incorporating letters and words, should be encouraged as a sort of ancillary play-therapy.
6. The teaching should be individual and intense.
7. In order that the child may concentrate upon learning to read, write, and spell, some subject or subjects may have to be sacrificed from the school curriculum. Thus, it may well be considered more important for the dyslexic to lose his or her disability than to try and cope with some less essential subject such as Latin or algebra.
8. In uncomplicated cases of dyslexia, i.e., where no serious neurotic problem exists, psychological treatment is unnecessary and perhaps even unwise.

Prognosis

That dyslexics are totally incapable of learning to read is a fallacy. With appropriate instruction, dyslexics can make considerable progress, and they may attain sufficient ability to read for all practical purposes.

Autism*

Definition and Incidence

Autism is a "childhood psychosis" (a condition "in which a child behaves most or all of the time in ways that are extremely strange and unpredictable, even considering the child's age and level of intelligence").

The incidence of autism in industrially developed countries is generally between four and five per 10,000. Autism almost always begins within the first two years of life, and boys are affected more frequently than girls.

Symptoms

Each autistic child is an individual, different in many ways from other children with the same diagnosis. This is partly because the condition may be present in any degree varying from very mild to very severe, but also because each child has his or her own personality, which somehow comes through despite his or her handicaps.

The following symptoms may appear to a greater or lesser extent in every autistic child.

1. Unusual response to sound: appears insensitive to even loud noises but may respond to specially selected noises (such as candy wrappers); is *not* deaf.

2. Difficulty in understanding speech: pays no more attention to speech than to any other noise; does not comprehend speech.

3. Difficulty when talking: some never acquire speech; those who do talk exhibit "echolalia" (repeating words after someone else); speech and language development is slow. Uses "you" to refer to self.

4. Poor pronunciation and voice control: may use a "special voice"; may drop last letters of words.

5. Problems in understanding things that are seen: may attend to movement and outline, and not to detail; does not look directly at people; may gaze fixedly at an object of interest.

---

*The material in this section is adapted from *Autistic Children: A Guide for Parents and Professionals*, by Lorna Wing, M.D., D.P.M. Secaucus, N.J.: Citadel Press, 1972.

6. Problems in understanding gestures: inability to use or interpret gestures; may take someone's hand and place it on a desired object, instead of pointing at it.

7. Use of the senses of touch, taste, and smell to explore the world: may seem insensitive to pain or to extreme temperatures.

8. Unusual bodily movements: may flap arms and hands; may tend to walk on tiptoe or spin around without becoming dizzy; may twist and turn fingers or twiddle string or small objects.

9. Clumsiness in skilled movements: some are graceful in walking or climbing and balancing; some are clumsy in these same situations; some are skillful in fine motor dexterity; some aren't. All are immature in their movements; have difficulty copying movement sequences of others; and have directional (left/right, up/down) confusion.

10. Aloofness and social withdrawal: behaves as if other people didn't exist; can be made to respond if approached correctly; tends to become more affectionate with age.

11. Resistance to change: has routines, favorite objects, and special collections, and tends to react violently if these patterns or objects are disturbed.

12. Special fears: may be oblivious to real dangers, but develop fear of such things as balloons, or other everyday objects or events.

13. Socially unacceptable behavior: e.g., screaming in public places or taking off clothes; difficult to control because of child's inability to understand speech.

14. Inability to play: does not develop normal play; may be interested in an activity as long as someone is "playing" with him or her, but seems not to know how to play on his or her own.

Causes

Early theories of cause posited an emotional basis to the problem of autism. They stressed the importance of early emotional trauma, bad early learning experiences, or "abnormal" parenting (parents were accused of having coldly rejected their child). These theories are now generally discredited.

Many people now think that a physical cause (also called "organic" cause) is most probable. They point to the fact that about one-third of all autistic children have other abnormalities of the brain and nervous system as well as their autism. They observe the many problems that the children have in understanding and using any kind of language, and their difficulties in coordination of skilled movements that closely resemble those found in other conditions known to have a physical cause.

Examples of physical cause might be a brain tumor, some brain injury, or an infection in early childhood. More often, however, it is not possible to find any definite reason for the behavior because, as yet, methods of examining the function of the brain are limited.

Diagnosis

Autism is behaviorally similar to certain other disabilities. In order to diagnose a child as autistic, a physician must determine that the child's behavior is not caused by any of the following conditions:

- congenital deafness
- congenital aphasia (difficulty in understanding or producing words)
- visual problems
- mental retardation
- elective mutism (a speech and behavior disorder)
- other types of childhood psychoses

Treatment

Autistic children's handicaps are severe. They affect all the activities of daily living and they are usually lifelong, though tending to a slow improvement. There is no known cure for these handicaps, but that does not mean that nothing can be done. The children can be helped to find ways around their difficulties with special methods of education, both at home and at school. In many ways the problem is similar to that faced by the parents and teachers of deaf or blind children. It may not be possible to cure the handicaps, but the children can be taught to make the best use of the skills they do possess. Some of the children have too many additional handicaps to make much progress, but even in these cases it is worth trying to improve the worst behavior problems to teach simple self-care.

Prognosis

A study has been made of 63 adolescents and young adults who had been diagnosed as suffering from autism in early childhood. It was found that 14 percent did well and were functioning at a generally good level. A further 25 percent made some useful progress, although they were still markedly abnormal. Most of the rest had become less difficult in behavior although their handicaps were still marked; but a few, particularly those in institutions, had remained unchanged or had regressed.

Cerebral Palsy*

Definition

The term "cerebral palsy," as currently used, includes a group of nonprogressive (stable) disorders resulting from malfunction of the motor centers of the brain, characterized by paralysis, weakness, incoordination or other aberrations of motor function, which have their origin prenatally, during birth or in the first year or two of life. Cerebral palsy encompasses the neuromotor manifestations of organic brain damage and occurs in conjunction with other manifestations of it such as seizures, mental retardation, various sensory defects, and behavior or emotional disorders. It is not a specific type of brain damage, but it results from congenital defects, mechanical and chemical injury, and infection. It is a nonfatal (per se), noncurable condition that is frequently amenable to therapy and training.

TYPES OF CEREBRAL PALSY

There are five major types of cerebral palsy:

1. *Spasticity:* characterized by the pathologic (disordered) stretch reflex, increased activity of deep tendon reflexes, scissoring (of legs) and contractures affecting the antigravity muscles.

2. *Athetosis:* marked by involuntary incoordinate motion with varying degrees of muscle tension; reflexes are usually normal; during second year develops pattern of fine wandering movements of the fingers, hands, and feet.

---

*The material in this section is adapted from *Textbook of Pediatrics*, seventh edition, edited by W.E. Nelson, M.D., D.Sc.

3. *Ataxia:* manifest by lack of coordination due to disturbances of the senses of balance and kinesthesia (sense of body position and movement).

4. *Tremors:* may be intentional or involuntary motions with a rhythmic pattern.

5. *Atonia* or *hypotonia:* characterized by soft muscles and (usually) by increased deep tendon reflexes.

Mixed types of cerebral palsy are seen, but usually one form predominates. Spasticity is the most frequent type, which together with athetosis accounts for approximately 75 percent of all cases; seizures occur in approximately 25 percent.

Incidence and Diagnosis

Cerebral palsy is one of the leading causes of crippling in children; it is estimated that the prevalence rate is 100 to 600 cases per 100,000 population, the majority of known patients being under 21 years of age.

When one manifestation of brain damage is recognized, others should be suspected. Children who have a history of any of the factors outlined above should be observed carefully for abnormalities. The presence of any abnormality or of disturbances during the neonatal period, such as feeding problems, irritability or drowsiness, cyanosis (bluish discoloration of the skin), jaundice (yellow discoloration of the skin), respiratory difficulties, abnormal muscle tone, or seizures, should lead to a careful observation of the central nervous system.

The cases of more severe damage or deficit are usually apparent early in life, those of less degree should be suspected when there is a significant deviation from normal rates of growth and development or when there is persistence of infantile physiologic reflexes.

Some Aspects of Treatment

The orthopedist is concerned with developing and maintaining good body mechanics. This is accomplished by bracing, by physical therapy, and by surgery that is largely limited to tendon lengthening, to arthrodeses (the connecting of joints), and to muscle transfers in older children.

Training--resulting in functional improvement of body mechanics, muscular control, gait, use of hands, and in verbal communication--can be effectively carried out by parents under the direction of physical, occupational, and speech therapists.

Physiotherapy, most of which can be carried out by the parent (after instruction) should be begun in infancy to avoid development of contractures and to stimulate control of movement.

Prognosis

Prognosis is dependent on a careful appraisal of all factors related to the individual child, his or her family, and the community. In general, the child's intelligence is the best prognostic guide, so that psychometrics (the measurement of psychological variables, such as intelligence, aptitude, and emotional disturbance) should be employed.

Evaluation Approaches

These approaches are provided to give teachers the opportunity to build evaluation into the day-to-day activities in the EXPLORING CHILDHOOD materials. Teachers can adapt these suggested approaches to the goals and needs of their individual classes. Students and teachers should share and discuss the purposes, expected outcomes, and actual results of the evaluation approach chosen.

Approach	Description of Activity	Purpose	Evidence of Student Learning
Discussion (Small group or whole class)	Discussion of children with special needs, considering the adolescent's feelings, perceptions, and misconceptions about people with special needs.	To evaluate students' ability to consider what it means to have special needs.	Students can articulate a number of different kinds and types of special needs. Students can articulate misconceptions they have had about children with special needs and relate those factors and experiences which led them to conclude that their perceptions were not accurate. Students can express the feelings they have had about children with special needs, e.g., fear, pity, helplessness, etc.
Observation	Have students observe children with special needs at a fieldsite to consider the resources and needs of these children.	To evaluate students' ability to: · detect particular strengths and needs of children with special needs; · consider how these needs are provided or not provided for; · consider through observation situations which can be dangerous or frustrating situations for children with special needs.	Students can provide notes which indicate an understanding or awareness of children's physical, emotional, academic, and social needs. Students can provide notes which indicate an awareness of how these needs are provided or not provided for at the fieldsite. Students can provide notes which indicate an awareness of things or times which: · might be frustrating or dangerous to a child with special needs; · might be frightening to a child with special needs.

Approach	Description of Activity	Purpose	Evidence of Student Learning
Interviewing	Divide the class into small groups and have them develop questions for an interview with a resource person who is knowledgeable about a particular special need. On the day of the resource person's visit, form an interviewing panel with a representative from each group. Have the panel interview the resource person about the particular special need in question.	To evaluate students' ability to: · consider the viewpoints, experiences, and work of someone who deals with a particular special need; · understand a particular special need.	Students can ask questions which demonstrate a rudimentary knowledge of the particular special need. Students can ask questions which elicit information about diagnosis, treatment, available facilities and resources, parental involvement, developmental patterns, moral and ethical issues, etc. related to the particular special need. Students can ask questions which take into consideration the needs and feelings of someone who might have this particular special need.
Role Play or Written Scenario	Have students role play someone with a special need, e.g., blindness, deafness, etc., and someone who assists or teaches the individual with a special need.	To evaluate students' understanding of the role of the person with special needs, and the role of the person who is assisting that individual.	Students can present depictions realistic of individuals with special needs and the persons assisting those individuals. Students can articulate what they learned from the experience (e.g., their feelings, needs, abilities, as well as limitations).

Teacher's Guide
for No Two Alike

Developers:
Norma Arnow
Marjorie Jones
Emma Wood Rous, Coordinator

"Hyperkinesis," "Dyslexia," "Autism," and "Cerebral Palsy" (Appendix IV) were developed by Margaret Janey.

Editor:
Nancy Witting

EXPLORING CHILDHOOD PROGRAM

Director:
Marilyn Clayton Felt

Curriculum Coordinator:
Ruth N. MacDonald

Module Head:
Susan Christie Thomas

Project Manager:
Kathleen Maurer Horani

Senior Scholars:
Jerome Kagan, Professor of Human Development, Harvard University

James Jones, Assistant Professor of Social Psychology, Harvard University

Freda Rebelsky, Professor of Psychology, Boston University

Consultants:
Elaine A. Blechman-Beck, Assistant Professor of Psychology, Yale School of Medicine, Yale University

T. Berry Brazelton, Pediatrician and Clinical Assistant Professor, Harvard University

Urie Bronfenbrenner, Professor of Human Development and Family Studies, Cornell University

Jerome S. Bruner, Watts Professor of Psychology, Department of Experimental Psychology, Oxford University

Betty H. Bryant, Nursery School Director, Center for Child Care Research, Educational Testing Service, Princeton, New Jersey

Courtney Cazden, Professor of Education, Harvard University

Joan Goldsmith, Co-Director, The Institute of Open Education/ Antioch Graduate Center

Patricia Marks Greenfield, Associate Professor of Psychology, University of Calfornia at Los Angeles

John Herzog, Associate Professor of Education, Northeastern University

David Kantor, Director of Research and Development, Boston Family Institute

Eli H. Newberger, Director, Family Development Study, The Children's Hospital Medical Center

Ed Tronick, Associate in Pediatrics, Harvard Medical School, Harvard University

Robert Selman, Clinical Psychologist, Judge Baker Child Guidance Center, Boston, Mass.

Beatrice Blyth Whiting, Professor of Education and Anthropology, Harvard University

Developers:
Norma Arnow
Wendy Johnson Barnes
Ellen Grant
Rogier Gregoire
Toby Grover
Patricia Hourihan
Margaret Janey
Peggy Lippitt
Ronald Lippitt
Karlen Lyons
Lucy Lyons
Pamela Matz
Jim McMahon
John Nove
Judith Salzman
Jeanette Stone
Ianthe Thomas
Juliet Vogel
Sandra Warren
Dennie Wolf

Filmmakers:
Henry Felt
John Friedman
Mark Harris
Lynn Smith
David Vogt

Film Staff:
David Barnett
David Berenson
Frank Cantor
Elvin Carini

Edward T. Joyce
Allegra May
David Nelson
Charles Scott
Dan Seeger
Charles White, Jr.

Editors:
Marcia Mitchell
Marjorie Waters
Nancy Witting

Design:
Myra Lee Conway
Roz Gerstein
Diana Ritter
Michael Sand
Karen Shipley
Judy Spock
Alison Wampler

Production:
Patricia A. Jones
Scott Paris

Parent Education:
Louis Grant Bond
Naarah Thornell

Teacher Education:
Michael J. Cohen
Marjorie Jones
Edward Martin
Barbara S. Powell
Emma Wood Rous

Evaluation:
Geraldine Brookins
Martin Chong
Catherine Cobb
Joan Costley
Sherryl Graves
Aisha Jones
Eileen Peters

Regional Evaluators:
John R. Browne
Karen M. Cohen
Judith McMurray
Mark Walker
Kaffie Weaver

Regional
Field Coordinators:
Florence J. Cherry
Thomas A. Fitzgerald
Andrea J. Love
Annie Madison
T. David Wallsteadt
Dianne H. Willis

Support Staff:
Marylene Altiere
Florence Bruno
Genevra Caldon
Bushra Karaman
Judith Knapp
Ruth Kolodney
Maria Rainho
Barbara Connolly Sweeney
Denise Weaver

Distribution Coordinator:
Steve Westlund

EDC SCHOOL AND SOCIETY PROGRAMS

Director:
Janet Hanley Whitla

Project Directors:
Marilyn Clayton Felt
Vivian Guilfoy
Cheryl Healer
Ruth N. MacDonald
Susan Christie Thomas

Director of Evaluation Services:
Karen C. Cohen

Director of Field Services:
Dennen Reilley

EXPLORING CHILDHOOD has been developed by EDC School and Society Programs under grants from The Children's Bureau, Office of Child Development; the National Institute of Mental Health; and with the support of the Office of Education.