EARLY CHILDHOOD PARAPROFESSIONAL

HUMAN DEVELOPMENT

SECTION A

Early Childhood Paraprofessional Module

Materials and Equipment Required

Computer and LCD
Flipchart and easel or dry erase board
Pre and Post assessments for each participant
Handouts for each participant
Materials for selected Simulation Activities

Before the Training

1. Prepare materials for Simulation Activities
2. Have participants sign in
3. Administer pre assessment
4. Provide participants with handouts
5. Stress the importance of gaining an understanding of the principles and patterns of typical human development before learning about the factor that cause or impede "normal" development.

Early Childhood Paraprofessional Module

Human Development – Section A

Overview

How children, youth and adults develop and move from one stage of life to others has fascinated humankind since recorded time began. How do infants unable to communicate become teenagers who spend most of their waking hours on the phone with their friend? How do babies unable to crawl or walk become adults who jog and run marathons? Myths and folklore exist in all cultures to explain physical, cognitive, social and emotional development, and in most, rituals mark the rites of passage from childhood to adulthood.

Over the years, several theories about development have evolved. Jean Piaget focused on how children develop cognitively. Erik Erikson centered on the stages of social and emotional development in children and adults. Other experts looked at patterns and phases of physical development in children as well as stages of moral development and how children and youth move from one level to another.

Principals of Human Development

Instructional Objectives:

1. Paraprofessionals will be able to explain why typical development in all children follows predictable patterns.
2. Paraprofessionals will be able to explain what is meant by typical development in terms of cognitive growth, physical/sensory growth, social/emotional grown and language/communication development.
3. Paraprofessionals will be able to describe characteristics of infants and young children at each year from birth to five.

Activity 1- **Brainstorming**   15 to 20 minutes

Divide the participants into three small groups. Ask the individual groups to brainstorm, based on personal experiences, and list typical characteristics of children of different ages.
   Group 1 – brainstorm characteristics of babies from 10 days to 6 months of age.
   Group 2 – brainstorm characteristics of babies from 1 year to 2 years of age.
   Group 3 – brainstorm characteristics of children from 3 years to 5 years of age.

Have participants share the responses they have listed on flipchart or dry erase board.

Dialogue for Trainer

Principals of Typical Human Development

In a training program for paraprofessionals working with children with disabilities, trainees might wonder why they should learn about "normal" human development. Wouldn't it be enough just to learn about children with disabilities and other special needs and the factors that cause them and their families to require individualized education programs and services. In fact, wouldn't it be more useful and wouldn't it save time?

The fact is that children with disabilities have more in common with their chronological age peers without disabilities than they have differences. In most ways their behavior and patterns of development conform to the behavior and patterns of development of children and youth described as typical or "normal." They have the same physical needs, interests, joys, fears and sorrows. Frequently instructional interventions are the same for all children, disabled or not. Our expectations for children with disabilities or who are at risk for other reasons should be the same as our expectations for all children: To grow and to develop to their maximum potential and to live and participate fully in the life of the community.

All infants, toddlers and young children are individuals with traits and characteristics that make them unique. The question invariably arises, if children are so distinct how can there be patterns of "normal" development? The answer is that although we do develop in our unique ways at our own pace we also pass through certain predictable stages. Indeed, all people grow and develop in patterns and stages that may vary in the length of time required to complete each sequence, but the patterns are predictable from one person to another.

Theories of Development

Refer participants to Handout 1 – Developmental Theorists

Several prominent, theories exist about child development. No single theory exists. Educators should elect to borrow critical concepts and strategies from each theorist in their professional practice.

Maturationist Theory: Gesell/Genetics
Gesell developed this theory. The maturationist theory holds that most of what children become is inherited at birth and their genetic makeup. Gesell taught that children are genetically predetermined, therefore children would walk, talk, and read for example, at about the same age because these skills emerge in a way that is predetermined at birth. Gesell developed the Developmental Milestones.

Gesell's theory is about genetics.

What this means to me as an educator:
- **Some characteristics of children are genetically determined at birth and I must appreciate and accept diverse interpersonal styles, temperaments, physical and mental abilities that are part of children's biological heritage.**
- **I should adapt classrooms to meet the unique inborn traits of individual children rather than expect children to adapt to classrooms.**

Behaviorist Theory: Skinner/Environment

The person that holds this theory is Skinner. This theory states that most of what humans become is shaped by the environment. Skinner believes that what children are and become is determined by experiences in their lives. From this view, a child's mind is a "blank slate" to be gradually filled by the environment.

Skinner's theory is children are born with minds that are "blank slates" and adults can shape their learning through positive reinforcement.

What this means to me as an educator:
- **I can use positive and specific feedback to influence children's behavior.**
- **I should behave as I wish my children to behave. (I will model positive behavior.)**

Psychosocial Theory: Erikson/Social and Emotional

This theory focuses on the formation of personality. This theory holds that healthy personality and emotional development is characterized by a resolution of inner conflicts. The adult's role is to promote children's emotional health by providing appropriate opportunities for the gratification of drives. Erikson developed the Eight Stages of Emotional Development.

Erikson's theory holds that a child's positive emotional state is critical to each stage of emotional development.

What this means to me as an educator:
- **I should be nurturing and responsive to the needs of the infants and toddlers in my care so they will develop trust.**
- **I should encourage autonomy – an emotional state in which children strive to be independent.**
- **I should allow exploration and self-expression and avoid punishment or over restriction.**
- **I should promote a sense of initiative by encouraging children to assert themselves, make creative attempts, take risks, and reach out to peers.**
- **I should promote a sense of feeling competent by providing many experiences in which children experience success.**

Cognitive Theory: Piaget/Cognitive
The cognitive theory holds that mental growth is the most important element in children's growth. Piaget's principle of this theory is that knowledge is constructed through the action of the learner. Learning experiences should have elements of both familiarity and novelty. Piaget developed the Stages of Cognitive Development.

Piaget's theory holds that mental growth is constructed through the action of the learner.

Sociocultural Theory: Vygotsky/Cognitive/Social/Language
Vygotsky's ideas are similar to Piaget's. However, Vygotsky's theory assigns greater importance to external influences such as language, social interactions, and the larger society. Vygotsky holds that adults and peers can "scaffold" children's learning by using language and other social interactions to guide thinking. When children are faced with problems they can solve on their own, adults should not interfere. If tasks are so challenging to a child that they are insurmountable, adults should offer direct solutions. Vygotsky developed the idea of Zone of Proximal development. Zone of Proximal Development is a situation in which a problem or task is only slightly above a child's ability level. In this zone, adults can ask questions or give hints that allow the child to solve the problem independently.

Vygotsky's theory is about building/"scaffolding" children's learning through social interactions and verbalizations with other children and adults. Independent thinking is an ultimate goal of teaching.

What this means to me as an educator:
- **I should provide interesting experiences, ask questions, and pose challenges that lead children to actively solve problems and construct their own understandings of the world.**
- **I should scaffold children's learning by asking questions, prompting, or giving hints when a child is within the zone of proximal development – or when the solution to a problem is just beyond the child's level of ability.**

Ecological Systems Theory: Bronfenbrenner/Ecology
Bronfenbrenner developed this theory. His thoughts are that a child's development is influenced by the personal, social, and political systems within which children live. Interactions between the family, school, community, social and political system, and the individual child will determine developmental outcomes.

Bronfenbrenner theory about ecology could be summarized by the idea of "it takes a village to raise a child."

What this means to me as an educator:
- **I must realize that classroom intervention alone will not ensure positive child development. Family, community, and social factors must also be optimal for children to learn and be social.**
- **I must help parents and families access community resources.**
- **I should become knowledgeable about and establish relationships with local service agencies and should ensure that parents have access to these agencies.**
- **I must expand my role to include advocacy.**

In summary, a child development theory is a system of beliefs about how children grow, learn, think, and behave. There are several prominent theories of child development; each can be applied to solving social problems or promoting learning in a classroom. It is suggested that each be considered for the development of the whole child.

Brain Development:
All areas of development are regulated by one marvelous organ – the brain. One of the most significant physical changes in infancy is brain growth. A baby's brain develops at an astonishing rate: by age 3, it is as complex as it will ever be.

Since the brain grows so rapidly in infancy, this period is considered a prime time for neutral growth. It is argued that a primary responsibility of care givers and parents is the "the day-to-day" care of young children's brains. Even infants with severe brain-related disabilities – autism or Intellectual Disability – benefit from early intervention programs.

This prime time is also a period of great vulnerability. Brain development is significantly impaired by *in utero* exposure to drugs, child abuse, maternal depression, and other factors. Even in these cases, however, early intervention can offset such negative influences if provided in the first 3 years of life.

Stages of Development

Observation of infants and young children forcefully demonstrate that everyone passes through predictable stages of cognitive, physical/sensory, social/emotional and language development. Because development is regular, patterned and predictable it is referred to as normal or typical. When children deviate from the "norms" they may require special services and individualized education programs.

Development is a step by step process. For example, learning to walk may involve as many as fifteen steps, beginning with pulling to a standing position and ending with walking without holding on. Most children progress through each step rather than skipping from Step 1 to Step 10. Because of these sequential patterns, determining a child's level of development is important so the child can be assisted to reach the next step.

The terms "stages of development" and "characteristics of certain ages" are general. To say the "average" four year old does certain things does not mean that every four year old acts in the same manner.

Individual development in physical, cognitive and social/emotional area does not necessarily proceed evenly. One child may be at a different developmental age for each area. It is likely, however, that the child who is accelerated in one area will be advanced in other areas as well. An obvious exception is a person who has a physical disability who might, therefore, be delayed in acquiring physical skills but is not delayed in other areas.

A second important concept is that development generally proceeds from the concrete and simple to the abstract and complex. For example in cognitive development children first become aware of people, objects, or events. From there they progress to logical thinking and are able to sort things into categories, classes, order. The next step in the sequence is problem solving and developing rules and guidelines for coping with the environment and society in general.

Finally, the acquisition of language is unique to humans. Language fills important functions for us: it provides us with a means to communicate and socialize; it enables us to transmit culture from generation to generation and it becomes a vehicle for thought. Babies, regardless of where they are born, are capable of producing every sound used in all languages used on earth. Infants' babbling encourages older persons to talk to them, thereby teaching infants the sounds used in their home environment. By six months of age, the sounds children make will be only those they hear; and all other sounds are not made or practiced. In this way, all humans learn to speak the language and the dialect that is spoken where they are raised. It is important to note that children will understand language before they speak it.

Refer participants to Handout 2 – Basic Principles of Human Development

Development in all people is similar. While every person is unique, development occurs in sequences that are predictable. For example: All babies sit alone before they walk.

Development is an orderly process with stages or patterns that can be predicted. Knowing the predictable sequences of behavior helps in recognizing typical/normal, delayed or accelerated patterns of behavioral change and growth and enables parents and educators to develop individualized programs.

Development proceeds from the general to the specific. For example infants move their entire arm in a random manner before they can control their hands and fingers to pick up a toy.

Development proceeds from the upper portions of the body toward the lower portions – from head to toe. This "cephalocaudal" development means that children gain control of their head and neck movements before they are ready to sit alone.

Development proceeds from the center of the body to the outer body parts. This "proximal distal" development means that children can hold a ball before they can tie their shoes.

Development proceeds at different rates. In a person's developmental sequence, there are periods of accelerated growth and gradual growth. From birth to age five, a child's development is characterized by rapid physical and cognitive growth; from 5 to 11, physical development slows down; during adolescence, there is rapid physical growth again.

Development can proceed at different rates within an individual person. For example, a person may have delayed cognitive and language development and have typical physical development.

Physical, cognitive, social and emotional development are interrelated and affected by the interaction of heredity and environment. For example, a person with Intellectual Disability may develop at different rates depending on whether or not he/she is reared in an institution or at home with access to early family intervention and education services.

Refer participants to Handout 3 – Terms Used in the Study of Human Development (2 pages)

Cognitive Development – The process of acquiring knowledge and information as a person interacts with the environment and culture. Cognitive development depends on growth inside the person, such as the development of curiosity and the desire to learn, as well as the impact of the outside environment.

Communication – Is the transmission of messages from one person to another. It may be accomplished in myriad ways including eye contact, posture, facial expressions, gestures, writing, and speech.

Development – The growth of the person in predictable patterns.

Developmental Delay – A term used to describe an observed difference in a person's actual growth and behavior and the typical growth and behavior expected of people of the same age.

Emotional Development – The process in which the person acquires feelings about him/herself and other people.

<u>Physical Growth</u> – A term used to refer to an increase in size, height, weight, knowledge and skills.

<u>Human Development</u> – A term used to refer to the study of a series of patterned and predictable changes that occur as a person grows and learns how to interact with the environment.

<u>Language</u> – Is the organized system of symbols people in various societies use to communicate with one another. These symbols may be spoken, written or gestured.

<u>Learning</u> – The acquisition of knowledge and skills as children and youth interact with their environments, caregivers and teachers. Learning is both receptive and expressive. Receptive learning is under the control of the learners who "take in" or assimilate information about their environments and experiences. Expressive language is strongly tied to reinforcement provided by the learner's environment. For example, a person may know the concept, but not use the word unless his/her environment encourages the use.

<u>Maturation</u> – The growth of a person from within, the process of acquiring cognitive, social, emotional and language skills that increase with age.

<u>Normal/Typical</u> – Averages or standards against which the behavior or development of a person is compared.

<u>Physical/Motor Development</u> – The sequence or rate at which a person acquires motor skills and learns to control his or her body. It is characterized by changes seen in the external body and by unseen internal changes in the organs, muscles, blood, bones and nervous system.

<u>Social Development</u> – The general process by which a person acquires the beliefs, skills, values, behavior patterns and other characteristics considered necessary for interacting with other humans in a particular society/culture.

<u>Speech</u> – Speech is the organized production of sounds to form words or word groups.

<u>Theory</u> - A theory is a belief about something.

Refer participants to Handout 4 – Developmental Checklist

The Developmental Checklist shows the typical signs of growth in young children as determined by the Denver Developmental Screening Test II. Many children develop faster than this guide indicates. Children who develop slower than this, however, may have special needs. The earlier we recognize that a child is demonstrating difficulties the earlier we can provide intervention and support.

* The Denver Developmental Screening Test II Checklist is only one of many developmental checklist tools.

Birth to 24 months of age is the time of greatest growth in children. They go from being dependent on parents for food, movement and stimulation to being able to control these things themselves. By the end of this age, they can walk and climb alone, tell caregivers what they want, feed themselves and entertain themselves for short periods of time. This is a time of self-centeredness and increasing independence. Children of this age are not selfish; rather they can only see the world from their own viewpoint. The world is what they can do to it. The world is action and making things happen. The skills developed during this time are the foundation for all later development. The skills learned can be divided into three broad categories: interactions, communication and self-help.

Interactions include all the skills children need in order to know how to act with family, friends and other people. Included are skills related to how to use toys and other objects in the environment. Children need to use them at home in school and in a wide variety of other places, e.g., grandma's house, the playground, the grocery store and the baby-sitter's house. The skills that help determine how children are able to interact are fine motor, gross motor, communication, cognitive and social skills.

Communication includes all the skills necessary for children to understand language used by the people around them as well as the skills necessary for children to use language themselves. Included are skills which are needed for talking and also for signing or using a picture communication system. Other skills involved in the area of communication are cognitive, interaction and motor areas of development. Sometimes a child will talk more in some situations than others. For example, many children will use more language at home than they will when they first start in a classroom. Often children will "clam up" around strangers or when requested to show that they know a word or phrase. Because of the difficulty in getting children to use their language skills in new environments, input from parents, baby-sitters, grandparents, etc., as to what the child really can do is very important.

Self-help includes the skills necessary for children to feed, dress and bathe themselves. They are the skills that decrease a child's dependence on parents and caregivers and the amount of time required for physical care giving. Professionals sometimes refer to this as the burden of care because of how tiring performing these activities can be for parents. Skills from gross motor, fine motor and cognitive are all involved in performing self-help activities.

Between the ages of 24 to 36 months is one of many changes for a child. Children at 24 months are very different when compared to 36 months. It is a time for practicing skills that a child has learned earlier and to become more "grown-up." They are now learning when and where to use skills. Children continue to need help from their family, neighbors and environment to learn how to use these new skills to interact and communicate in more complex ways. They may seem like babies at times and more like independent children at other times. For example, they may want help from others to

wash their hands or play a game and twenty minutes later they want no help to do the same tasks. Sometimes this makes understanding what a child wants very difficult for caregivers. By the end of this age, however, the child has mastered many more language skills, so that he/she becomes a talker and explainer as well as a doer. Children accomplish these skills through interaction, communication and self-help experiences.

Interactions become skills necessary for a child to know how to act with other individuals. Children learn how to use objects, materials, and toys in their environment. This includes a child knowing what to do when she/he is alone, so that she/he can play by him/herself. Children learn how to begin interactions and how to respond to others once the interactions begin. There will be times when these interactions are quiet activities such as reading a book, playing with trucks and cars, or drawing a picture with crayons. There will be times when these interactions are very active, like running and screaming, climbing on the furniture and jumping off or riding a bike. Children will spend more time in active play at the beginning (24 months) of this stage and more time in quiet play at the end of this stage (36 months).

Communication skills include those involved in talking, signing, using a picture communication system, and understanding what is meant when adults and peers talk with the child. The skills in these systems include the cognitive, interaction and motor areas of development. During the 2 to 3 year age range, children may not be learning a lot of new words, but they are putting together the words they know and making longer and more complicated sentences. They also understand longer and more complicated sentences said to them. Children of this age are beginning to use their communication system to be as independent as their motor system allows them to be. For example, they will sometimes ask others to get objects for them or to perform specific actions, rather than do them for themselves. This does not always happen, as they sometimes ask for an object while they are getting it for themselves.

Self-help skills include feeding, dressing, toileting, and bathing. These routines include component skills of gross motor, fine motor, communication, cognition, and interaction. Two to three year old children are learning how to use these skills to finish each routine, but sometimes they want to play during these routines. They want to do them at their own pace and they want to make the choice of when and how to do each routine. Many times they use their skills during these routines to be independent from what others around them want them to do. They want to experiment and try combinations of new skills during these routines, such as drinking their juice by dipping from their glass with a spoon.

Children between the ages of 3 and 5 years learn by observing adults and peers. While they are self centered they need companionship and to be able to play with children the same age. They begin to lean to take turns and share, and they move from parallel play to cooperative play. They are interested in talking to new people and visiting new places and they begin to expand skills through the increasing use of imaginative play and the use of other methods for satisfying their curiosity.

During this period the rate of physical growth begins to slow down. Children begin to play with toys that can be manipulated, for example, they enjoy playing with clay, driving nails and pegs, building towers using small blocks. They can walk on a line and hop on one foot, ride and steer a tricycle.

Socially, emotionally and cognitively children between 3 and 5 years are exploring and learning about their world. They are seeking independence; they are forming strong attachments to caregivers and require a great deal of attention and support from adults. Their attention spans are short and they can be easily diverted. They always seem to be on the go.

We have discussed typical or normal human development, now we will look at factors that may impede human development. This section focuses on causes and categories of disabilities. No two states use the same definition for various types and levels of disability, this is general information.

Refer participants to Handout 5 – Factors That May Impede Human Development

There are several factors that may lead to a child having developmental and other disabilities. They may be genetic or they may be environmental. They can occur during prenatal, natal or postnatal periods.

Physical and other characteristics for all people are shaped by our genes. They determine whether we are tall or short, bald or have brown or red hair, the color of our eyes and more. Sometimes disabilities and other conditions are inherited as a result of the genes that exist in our parents. Many times a child's parents do not have the disability; they carry the genes from earlier generations. Genetic causes may cause mild or severe disabilities that may or may not be life threatening. Examples of genetically caused disorders are:

Down's Syndrome – a congenital condition characterized by physical malformations and some degree of Intellectual Disability. The disorder was formerly known as Mongolism. It is also called Trisomy 21 Syndrome because the disorder is concerned with a defect in Chromosome 21.

Hemophilia – a condition characterized by impaired coagulability of the blood, and a strong tendency to bleed.

PKU – also known as Phenylketonuria, is a congenital disease due to a defect in the metabolism of the amino acid phenylalanine. Persons with PKU are usually blue-eyed and blond, with defective pigmentation, the skin being excessively sensitive to light and tending to eczema.

Rhetts Syndrome – is a common developmental neurological disorder that has been reported almost exclusively in females. After normal development up to 7-18 months,

combinations of psychic deterioration that in a year and a half leads to: severe dementia, autism, loss of use of hands, ataxia, and a lack of head growth.

Sickle Cell – a serious, hereditary, chronic disease in which the red blood cells are rigid and crescent shaped. Because of the distorted shape, the red cells have difficulty passing through the small arterioles and capillaries and have a tendency to clump together and occlude the blood vessel.

Sometimes circumstances in a child's environment may cause the child to have a disability. Toxins in the air, water pollution, and lead poisoning are factors that may have an impact on a child's environment and lead to a disability. Another factor could be economic or other disadvantages for the family that make it difficult to provide experiences that stimulate or encourage learning.

Prenatal means before birth. Many disabilities are the result of something happening to the fetus while it is still in the mother's womb. If the mother has poor nutrition, has hepatitis or measles, uses drugs, alcohol, or smokes, her child may be born with a disability. Other factors that have been linked to these conditions are: medicine taken during pregnancy and food additives.

Natal means at the time of birth. Some disabilities result from conditions present at the time of birth. Being born prematurely, having a loss of oxygen, long labor, excessive hemorrhaging or loss of blood for the mother, early separation of the placenta (the part of the tissue that is attached to the womb) and direct injury to the head, if instruments are used, are some events during the birth process that may cause disabilities.

Postnatal means after birth. In some cases children become disabled after birth. Injury to the central nervous system may happen in many ways including severe blows to the head as a result of an accident or child abuse, the inability to breathe, poisoning, tumors, and infectious diseases such as meningitis or encephalitis.

Simulation Activities

Although we can never completely duplicate what it is like to have a disability, through simulations we can provide some understanding of what it might be like. The activities are designed to allow the paraprofessional to experience some of the difficulties created by various disabilities and to examine your reactions and emotions as a result of participating in the activities.

Try as many of the simulations as you can in the allotted time. Keep track of your feelings and reactions during the simulations. Once the time is over meet back in your groups and share experiences, challenges and insights gained during the simulation activities.

Simulation 1 – hearing loss

Materials: Cassette recorder and ear plugs

      1. Instructions: Ask the participants to work in pairs, carrying on a conversation with one individual wearing ear plugs

      2. Instructions: Use the recorder to record the following words: wish, three, pill, station, snow, watched, splinters, tick, mice and jump. The first recording should be done with voice muffled with a cloth or can. The second recording should be done with a lower volume and muffled through a cloth. The third recording should be completed in normal voice with normal volume. Participants will number a paper from 1-10 three times. (like a spelling test) Have participants write words as they are said from the recorder.

Simulation 2 – vision loss

Materials: blindfolds/sleepmasks, old glasses smeared with Vaseline, book or printed
          material

1.   Instructions: Place several easily identifiable objects into a bag, participants are to put on blindfold and identify object by touch.

2.   Instructions: Have participants put on the glasses and attempt to read.

Simulation 3 – physical disabilities

Materials: adhesive tape, wheelchairs, crutches, pen or pencil, pennies, paperclips, fork,
          glass, old shirt to button or unbutton.

1.   Instructions: Tape thumbs to palm of hands. Pick up small objects, button or unbutton a shirt, write your name.

2.   Instructions: Use wheelchair or crutches to navigate around the room, go to a water fountain, use a payphone.

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EARLY CHILDHOOD PARAPROFESSIONAL

INSTRUCTION

SECTION B

INSTRUCTION

Overview

Public Law 108-446, the Individuals with Disabilities Education Act (IDEA) was originally enacted in 1975, as P.L. 94-142, to ensure that children with disabilities had the opportunity to receive a free appropriate public education, just like other children. The most recent amendments were passed by Congress in December 2004, with final regulations published in August 2006 with an effective date of October 13, 2006. IDEA guides how the Arkansas Department of Education and school districts provide special education and related services to 70,000 eligible children with disabilities, ages 3-21.

Part C of IDEA for birth to 36 months is not a federal mandate service, but provides incentives for states to coordinate the services to children from birth to age three. States have the option of deciding whether or not they will participate in Part C services. Arkansas has opted to participate and is required to comply with the specific requirements.

Arkansas has a state mandate to provide all early intervention services as required in IDEA, Part C. The early learning, medical, and related services programs/interventions for the children and their families are developed by a multi-interdisciplinary team and contained in an Individual Family Service Plan (IFSP). The lead agency responsible for the Early Intervention program is the Developmental Disabilities Services, Division of the Department of Health and Human Services.

Prior to addressing instruction it is important for the paraprofessional or assistant to understand their role and to be familiar with the types of disabilities that may be seen in the early childhood setting.

Instructional Objectives:

The Paraprofessional will have knowledge of:

1. The importance of on-going assessment of a child's progress toward development/educational goals.
2. The importance of keeping accurate, relevant, on-going data on the progress of a child.
3. Description and use of developmentally appropriate curriculum activities and interactive teaching methods that promote inclusion of young children with disabilities in early childhood programs. These include:
   a. Developmentally appropriate practices
   b. Techniques for maintaining effective classroom environments
   c. Providing opportunities for structured and spontaneous play
   d. Strengthening communication and social skills
   e. Preparing materials for teaching functional language, cognitive, motor and self-help skills

**EARLY INTERVENTION
CATEGORIES OF DISABILITIES
BIRTH TO THREE YEARS**

Developmental Delay or Disability

Children who are experiencing a developmental delay or disability include those who have been diagnosed by a multidisciplinary team as having significant delay in one or more of the following areas of development: physical, communication, social or emotional, and adaptive skills. Appropriate testing, observations, and informed clinical opinion is used to identify a developmental delay or disability. The informed clinical opinion of qualified professionals in conjunction with evaluation results and quantitative data, will provide the information that the IFSP team uses to determine eligibility for the program. Quantified delays in the general ranges of a 25% or greater delay on assessment instruments that yield scores in developmental ages (months) should be considered a primary factor for eligibility determination. However, eligibility should not be based solely on one determining factor.

Diagnosed Physical or Mental Condition

Children are also determined eligible for services under Part C if they have a diagnosed physical or mental condition which has a high probability of resulting in developmental delay. Examples of such conditions include, but are not limited to:

1. Down Syndrome and other chromosomal abnormalities associated with Intellectual Disability
2. Congenital syndromes and conditions associated with delays in development, such as Fetal Alcohol Syndrome, intra-uterine drug exposure, prenatal rubella, severe microcephaly and macrocephaly, hydrocephaly, metabolic disorders, intracranial hemorrhage, malignancy or congenital anomaly of the brain or spinal cord, spina bifida, seizure disorder, asphyxia, respiratory distress syndrome, neurological disorder, including brain trauma or brain infection.
3. Sensory impairments, including visual and hearing
4. Maternal Acquired Immune Deficiency Syndrome (AIDS)

These diagnosed conditions are likely to result in significant developmental delays simply by virtue of their prognosis. Therefore, in accordance with federal regulations, children with diagnosed conditions such as these are by diagnosis eligible for the Part C Early Intervention Program. To receive services through the program there must be an instructional service area identified in which a 25% delay in one or more areas have been determined.

Process to Determine Eligibility

1. Multidisciplinary Evaluation

For children ages birth to thirty-six months, development is a product of a complex and sensitive interplay between psychological and social-emotional factors, physiologic status, genetic endowments, and learning experiences. These complex factors will impact all of a child's needs. As a result, in order to ascertain a child's abilities, a multidisciplinary evaluation must be completed.

The purpose of the multidisciplinary evaluation includes:

1. To provide accurate and reliable information relative to the developmental status of a child
2. To determine eligibility for services under Part C of IDEA
3. To determine a basis for the development of appropriate interventions

2. Eligibility

Eligibility simply means that a child qualities for the early intervention program. The term does not signify the array or level of services that the child should receive, only that appropriate services are to be made available to the child and family. The array and level of services that the child receives will be determined by the Individual Family Service Plan (IFSP), which is a document developed by and based on the results of the multidisciplinary assessment. The development of the IFSP must include the child's family. The IFSP will specify goals and objectives for the child and family, as well as the services that will be provided. Programming through IFSPs is reviewed at least every six months. After the age of 36 months, eligibility must be re-established through Part B of IDEA.

3. Individual Family Service Plan (IFSP)

The procedures for developing an IFSP are rooted in the concept that families have the right and ability to decide such issues as the services they want their children to have, the location of these services and the staff who will carry out the activities of the IFSP. The process assumes that early intervention staff will take on various roles that enable the family to participate actively both in planning and in implementing the objectives. The IFSP is reviewed at least bi-annually by the team preparing it. A report for parents is provided bi-annually on the progress of the IFSP. One individual is designated to serve as the service coordinator with responsibility for coordinating the services decided on by parents and other team members.

Components of the IFSP

1. General information about the child including name, address, parents or legal guardian, primary language
2. A statement of the child's current level of cognitive, speech/language, social and physical development
3. The child's strengths
4. A statement of family strengths
5. A statement of the outcomes to be achieved with the family and child and the criteria, procedures, and timelines for determining progress
6. The specific early intervention support services required to meet the unique needs of the child and family, including education, health/medical and other human services
7. The projected dates for starting, the service and expected duration
8. The names of the services coordinator with responsibility for implementation of the plan
9. Procedures for transition from home-based or other early intervention programs to appropriate services, if needed at age 3.

The paraprofessional may not see the entire IFSP, but will normally see those sections that are relevant to their daily encounter with the children they are working with. It is important to remember that the IFSP is a confidential document.

EARLY CHILDHOOD SPECIAL EDUCATION PROGRAM
3-5 ELIGIBILITY CRITERIA

Trainer Information

I.   **AUTISM**

   Definition:

   "Autism" means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, that adversely affects a child's education performance.   Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences.

II.   **DEAF-BLINDNESS**

   Definition:

   "Deaf-blindness" means concomitant hearing and visual impairments, the combination of which causes such severe communication and other developmental and education needs that they cannot be accommodated in special education programs solely for children with deafness or children with blindness.

III.   **DEAFNESS**

   Definition:

   "Deafness" means a hearing impairment that is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification that adversely affects a child's educational performance.

IV.   **HEARING IMPAIRMENT**

   Definition:

   "Hearing Impairment" means an impairment in hearing, whether permanent or fluctuating, that adversely affects a child's educational performance but that is not included under the definition of deafness.

V. MULTIPLE DISABILITIES

Definition:

"Multiple disabilities" means concurrent impairments (such as Intellectual Disability-blindness or Intellectual Disability-orthopedic impairment), the combination of which causes such severe educational needs that they cannot be accommodated in special education programs solely for one of the impairments. Multiple disabilities does not include deaf-blindness.

VI. NONCATEGORICAL/DEVELOPMENTAL DELAY

Definition:

"Noncategorical" means a condition of developmental delay which impairs a child's functioning and which has a high predictability of impairing normal developmental performance. "Impaired functioning" means that a difference exists between the child's expected level of development and his/her current level of functioning. The child is experiencing developmental delays in one or more of the following areas:

1. Cognitive development – the ability to use reasoning and problem-solving skills including conceptualization, comprehension and memory.

2. Communication development – the ability to effectively use and/or understand age appropriate language, including pragmatics, phonology, morphology, syntax, semantics and articulation.

3. Physical development – the ability to use gross motor skills for body control such as standing, walking, balance and climbing; and fine motor skills requiring precise, coordinated use of small muscles

4. Social or Emotional Development – the ability to develop and maintain functional interpersonal relationships and to exhibit age-appropriate social/emotional behaviors

5. Adaptive Development – the ability to engage in age-appropriate activities of daily living.

VII.   ORTHOPEDIC IMPAIMENT

Definition:

Orthopedic Impairment means a severe orthopedic impairment that adversely affects a child's performance. The term includes impairments caused by a congenital anomaly, impairments caused by disease (e.g., cerebral palsy, amputations, and fractures of burns that cause contractures).

VIII.   OTHER HEALTH IMPAIRMENT

Definition:

Other Health Impairment means having limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli that results in limited alertness with respect to the educational environment that is due to chronic or acute health problems such as asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia, and Tourette syndrome; and adversely affects a child's educational performance.

IX.   SPEECH OR LANGUAGE IMPAIRMENT

Definition:

"Speech and/or Language Impaired" means a communication disorder such as a deviant articulation, fluency, voice, and/or comprehension and/or expression of language, which impeded the child's acquisition of basic cognitive and affective performance skills.

Speech and language disorders can affect the way children talk, understand, analyze or process information. Speech disorders include the clarity, voice quality, and fluency of a child's spoken words. Language disorders include a child's ability to hold meaningful conversations, understand others, problem solve, read and comprehend, and express thoughts through spoken or written words.

1. **Speech disorder:** A speech disorder is an impairment of the articulation of speech sounds, fluency, and/or voice.

a. Articulation disorder - difficulties with the way sounds are formed and strung together, usually characterized by substituting one sound for another (wabbit for rabbit), omitting a sound (han for hand), and distorting a sound (ship for sip).

b. Fluency disorder - an interruption in the flow or rhythm of speech characterized by hesitations, repetitions, or prolongations of sounds, syllables, words, or phrases.

c. Voice disorder - characterized by inappropriate pitch (too high, too low, never changing, or interrupted by breaks); quality (harsh, hoarse, breathy, or nasal); loudness, resonance, and duration.

2. **Language Disorder**: A language disorder is impaired comprehension and/or use of spoken, written, and/or other symbol systems. The disorder may involve 1) the form of language (phonology, morphology, syntax), 2) the content of the language (semantics), and/or the function of language in communication (pragmatics) in any combination. Impaired language development is characterized by a marked slowness or gaps in the development of language skills.

X.   TRAUMATIC BRAIN INJURY

Definition:

Traumatic Brain Injury means an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child's educational performance. Traumatic brain injury applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition, language, memory, attention, reasoning, abstract thinking, judgment, problem-solving, sensory, perceptual, and motor abilities, psychosocial behavior, physical functions, information processing, and speech. Traumatic brain injury does not apply to brain injuries that are congenital, degenerative, or to brain injuries induced by birth trauma.

XI.   VISUAL IMPAIRMENT

Definition:

Visual Impairment, including blindness, means an impairment in vision that, even with correction, adversely affects a child's educational performance. The term includes both partial sight and blindness.

The IEP Process

The individualized education program or IEP is a written statement for a child with a disability that is developed, reviewed, and revised in accordance with IDEA. The IEP is in effect before special education and related services are provided to an eligible child and is implemented as soon as possible following the meeting where it was determined the child qualified for services and the IEP was developed.

As stated in 34CFR §300.22, an Individualized Education Program, or IEP, must be developed, reviewed, and revised in accordance with the requirements of the IDEA for each child with a disability. Each child's IEP must include a statement of how the child's disability affects the child's involvement and progress in the general education curriculum (i.e., the same curriculum as for nondisabled children). For preschool children, the IEP must indicate how the child's disability affects the child's participation in appropriate activities for preschoolers.

The IEP Team

The IEP team for each child with a disability includes
> The parents
> At least one regular teacher of the child
> At least one special education teacher of the child
> Where appropriate, at least one special education provider of the child
> A representative of the special education program who is qualified to provide, or supervise, specially designed instruction to meet the unique needs of children with disabilities
> An individual who can interpret the results of evaluations
> At the discretion of the parent or the special education program, any other individual or individuals who have knowledge or special expertise regarding the child

Components of the IEP

1. A statement of measurable annual goals, including academic and functional goals designed to meet the child's needs that result from the child's disability to enable the child to be involved in and make progress in the general education curriculum and meet each of the child's other educational needs that result from the child's disability
2. A description of how the child's progress toward meeting the annual goals will be measured
3. A description of when periodic reports on the progress the child is making toward meeting annual goals will be provided
4. A statement of the special education and related services and supplementary aids and services, based on peer-reviewed research to the extent practicable, that are to be provided to the child, or on behalf of the child

5. A statement of the program modifications or supports that will be provided to enable the child to advance appropriately toward attaining annual goals
6. A statement of the program modifications or supports that will be provided to enable the child to be involved in and make progress in the general education curriculum and to participate in extracurricular and other nonacademic activities
7. A statement of the program modifications or supports that will be provided to enable the child to be educated and participate with other disabled and nondisabled children in extracurricular and other nonacademic activities
8. An explanation of the extent, if any, to which the child will not participate with nondisabled children in the regular class and in extracurricular and other nonacademic activities

The paraprofessional may not see the entire IEP, but will normally see those sections that are relevant to their daily encounter with the children they are working with. It is important to remember that the IEP is a confidential document.

Observing & Keeping Good Data

The Importance of Observation

Acquiring and using objective skills of observation and keeping data are important to all paraprofessionals. Much of the information used to evaluate whether or not children are gaining new skills is acquired by careful observation and good record keeping. Written information that has been observed is called "data." It serves as a record of what is seen or heard to create an objective account of the individual's activities and skills. It is important to guard against biases and prejudices to avoid personal perceptions of the individual or their behavior.

Being a good observer is a critical skill when working with children in any kind of developmental/education setting. Learning to separate personal perceptions or biases from what is seen and recording exactly what is happening takes time. When it is learned, it enables paraprofessionals to contribute effectively to all the discussion about the instructional program and progress for any specific child.

Observation is systematically watching what a person does and says to record the behaviors used to make instructional decisions. Observation should:
    a) Be done for a specific reason
    b) Provide samples of a child's behavior over a period of time, in a variety of settings
    c) Be objective.

Objective Observation:

Watching events without being affected by personal biases/prejudices
Watching the event without guessing at reasons that cause the action
Watching the activity without judging whether it is good or bad
Producing an objective record states exactly what is seen and heard

Remember, you must be able to see or hear the behavior and you must be able to count the behavior.

For example, an observation that says, "Frank hit John on the arm twice within five minutes," fulfills both points. You <u>saw</u> Frank hit John, and you <u>counted</u> the hits as they happened. An observation that says, "Annie was her usual hyper self this morning," doesn't tell what the observer saw. It is a judgment call. Because it does not tell what the observer saw, and nothing was counted, there is no information for teachers or teams to build on when planning personalized instructional interventions.

Why We Observe Children

Get to know each child
Document learning and development over time
Basis for planning for each child and the group
Document behaviors that support concerns about a child
Improve teaching skills

Video – Getting to Know Children Through Observation   (26 minutes)

When We Observe Children

Have a focus for observations
Observe in varied situations and times of day
Record observations on each child over time
Use action words: run, clap, hit, build
Record what child says
Avoid labels: aggressive, shy, smart, competent, friendly
Avoid judgment words: angry, provoked, frustrated, lazy
Avoid interpreting behavior
Record what child can do
Record as events occur

Activity # 2 - Handout 6 - Observation or Judgment   (5 to 8 minutes)
Participants read scenario and select the words that demonstrate observation, judgments, labels or interpretations of the situations.   Participants share table discussions.

Keeping Data

There are several ways to keep data. These include: using a checklist, making anecdotal records, interviewing a child, parent, or other care giver, watching a specific child and making notes, keeping frequency and duration records.

Refer participants to Handout 7 – Types of Data Collection

Checklists – may be in the form of standardized checklists which include specific skills and behaviors based on developmental levels, or a list of behaviors compiled by a teacher. When paraprofessionals work with a checklist, they simply watch the child and record whether or not she/he is doing the behavior described.

Behavior Checklists – categorize and list specific behaviors, usually in specific developmental areas such as fine motor, cognitive, language, gross motor, etc. Usually, specific behaviors are listed in the sequence in which they occur in a "typical" developmental pattern. The person using the checklist simply checks off whether or not the child is able to perform that specific behavior. The checklists can be helpful in formally evaluating specific skills in the classroom or other areas. They can also be used informally to indicate strengths and possible areas where assistance is needed.

Anecdotal Records – these usually consist of a sentence or two written in a notebook that describe what the child is doing at a specific moment. When making an anecdotal record, only behaviors that can be seen or heard and behaviors that can be counted should be recorded.

Interviewing – this is a specific kind of record keeping, one in which the team is trying to determine what the child likes or dislikes, what his/her interests are, or other feelings or beliefs that cannot be observed. When interviewing, it is extremely important to record precisely what the child says. There is not room for editorializing in this kind of record.

Frequency or Duration Notes – sometimes the information that is collected refers to how often or for how long a behavior is occurring. For example, the team may want to know how many times a child talked to or communicated with his/her playmates. For this kind of record keeping, paraprofessionals will count the frequency of the behavior occurring to observe how long some behaviors last. For example, the paraprofessional might watch to see how long a child plays alone or with other children. In this case the duration is being timed.

Other Data Collection – paraprofessionals may be asked by their supervisors to keep a record of specific behaviors or demonstrations of skills for certain children. It is important for the paraprofessional to understand exactly what information the teacher/supervisor wants to know, why it is needed, and how it will be used.

Activity #3 – Data Collection - Handout 8

Instructional Interventions

Handout 9   Activity # 4   What is Your Learning Style?

Ask participants to complete the handout by checking the items under the three columns that they feel is a good representation of themselves.

Provide 5-8 minutes to complete the sheet, then lead participants in discussion of what their answers mean to them about how they prefer to learn and why it is important to identify the learning style(s) of children in order to design effective individualized instructional interventions.

If most checks were in column I – a visual learning style is preferred.
If most checks were in column II – an oral or auditory learning style is preferred.
If most checks were in column III – learning by doing is preferred; also called kinesthetic.

People learn in all different kinds of ways. Some learn most easily when they read words. Others learn better when they are given information verbally. Still others learn best when they can do the task. Information that is gathered on the learning style of a child will help in educational planning for the child.

Activity # 5 Reinforcers of Behavior

Working in small groups, have participants respond to the following:

1. Brainstorm a list of activities or events that serve as personal reinforcers for them
2. Describe programs they have participated in that supported their effort to change a behavior (lose weight, stop smoking).   Determine if negative or positive experience.

After about 5 minutes have participants share with the group.

All people, regardless of age or if the do or do not have a disability demonstrate similar characteristics or behaviors when reinforcers are used to change behavior.

Reinforcement is any consequence that increases the probability of a behavior occurring. Reinforcement is the most important consequence. It is far more useful and positive to increase the right behaviors, than to try to decrease the wrong behaviors. Put into context: wouldn't you rather have your supervisor focus on what you do right, rather than on what you do wrong? When we point out what a child is doing right they will repeat the behavior because it makes them feel good. It is important to remember that what is reinforcing to one child is not necessarily reinforcing to another. An example: one child may enjoy being hugged with verbal praise, while another child may withdraw with touch and the hug does not reinforce the behavior desired.

Developmentally Appropriate Instruction

Early childhood specialists increasingly are recognizing that effective child care and teaching practices for all infants, toddlers and young children with and without disabilities should be developmentally appropriate and family centered.

The concept of developmental appropriateness has two dimensions: age appropriateness and individual appropriateness.

Age appropriateness – Human development is based on predictable patterns of growth and change throughout life. These predictable sequences occur in all areas of development – language, social/emotional, cognitive and physical. A knowledge and understanding of typical development within the age span of the children served by the program provides a framework from which the instructional team plans appropriate experiences, prepares the learning environment and implements the program.

Individual appropriateness – Children have individual patterns and rates of growth, as well as individual personalities, learning styles and family backgrounds. It is essential that curriculum activities and adult interactions be responsive to these individual differences.

Curriculum Planning

In the past the curriculum activities in child care and preschool education programs for young children were usually teacher directed, stressed teaching pre-academic skills, and taught children to follow commands, not explore their environment or lean from trial and error. In today's early intervention and education programs, the activities are child-initiated, child-directed, teacher-supported and teacher-encouraged.

Carrying out developmentally appropriate practice has many components. In this training program for paraprofessionals we are concerned primarily with:

1. curriculum activities
2. adult-child interactions
3. ideas for materials and experiences that can be used to facilitate the inclusion of children with disabilities into child care and education programs

A developmentally appropriate curriculum for young children is designed to meet the needs of the age span of the children within the group and is implemented by the team with attention to the different needs, interests and developmental levels of individual children. Effective curriculum goals address all areas of a child's development: physical, social, emotional, language and cognitive through an interactive approach.

Arkansas uses the Early Childhood Benchmark which is a level of performance that can

be supported through observations, descriptions and documentation of a child's performance or behavior, and by samples of a child's work. This is often referred to as "learner outcomes".

Assessment

Using functional assessment strategies are the key to planning developmentally appropriate curriculum activities. Careful and on-going observations systemically recorded provide information about the needs, strengths, learning preferences, special interests and developmental levels of individual children. Interviews with parents and other caregivers provide information about family/cultural backgrounds, communication styles, and the goals of the family for their child that enhances the planning process.

Play-Based Learning

Refer participants to Handout 10 - How Play Changes with Social Development

Play is a primary vehicle for and indicator of physical, cognitive and social development in young children. In early childhood programs for children with and without disabilities spontaneous and formal play are core activities.

Researchers have established the importance of play as a mechanism for enabling children to progress through developmental stages. Through structured and spontaneous play activities children learn to:

1. have fun by themselves and with other children
2. make choices
3. increase independence
4. share and cooperate
5. solve problems
6. follow rules
7. use their imagination
8. complete tasks
9. lay the foundation for acquiring academic skills
10. improve sensory-motor skills

Learning Environments

Activity 6 Handout 11 - Classroom Environment

 Implementation of age and individually appropriate curriculum activities requires and environment that enables children to learn through exploration and interaction with parents, other adults, other children and materials.

Teachers and team members must take several factors into account as they design and prepare the environment. They include:

1. the overall schedule as well as changes in schedules for individual children
2. the availability of different learning/play centers
3. opportunities for outdoor play
4. availability of materials that will encourage children into use imagination and try out new ways of doing things

In center based programs, activities, materials, and equipment should be provided for a chronological age span. For example: books need to vary in length and complexity; puzzles vary in number and sizes of pieces.

Equipment required by children with disabilities should be designed to reduce isolation and facilitate inclusion. For example: positioning bolsters that look like stuffed animals or other items children enjoy playing with and barrel chairs designed to look like horses are effective alternatives to commercially made equipment.

Implementing Curriculum and Activities

The roles of adults in the learning environment are to stimulate learning, build self-esteem in children with disabilities and other special needs and challenge children to try new activities. Interactive teaching methods are effective strategies for supporting children as they grow and develop. Interactive procedures include:

1. asking questions and if necessary providing cues or suggestions to help the child respond
2. encouraging children to assist and learn from each other
3. systematically providing opportunities for children to try new experiences
4. responding to the needs of the child

The following sections contain suggestions for stimulating growth in language, cognitive, social and physical development in children with disabilities and other special needs.

Stimulating Growth in Language

Refer participants to Handout 12 - Strategies for Language Development

Supporting the development of communication and social skills in all young children is at the heart of any early intervention/childhood program. Teaching young children with disabilities to communicate and interact with adults and other children is of critical importance. Indeed most parents identify these skills as an urgent need because these skills will contribute to the successful transition of their child from early childhood and preschool programs into kindergarten and early elementary classes, and these skills enable their child to participate more fully in family activities.

As young children grow and develop they use oral language and other means of communication to:

1. make contact with and interact with caregivers and other children
2. learn about and understand their surroundings
3. coordinate and control their environment

Stimulating language growth in young children with disabilities requires imagination, patience, and interest on the part of caregivers and other educators. Communication and language instruction cannot occur at a specific time, but must occur throughout all activities in the child's schedule and routine. Paraprofessionals have many opportunities to help children learn language as they play with them, interact with them during other activities, show interest in what they are doing by asking questions, and reinforcing all attempts to communicate.

Strengthening Growth in Social and Cognitive Skills

Refer participants to Handout 13 – Curriculum Activities

The development of language, cognitive and social skills can not be separated. Young children learn though their experiences including:

1. observing others
2. trial and error
3. repetition or practice
4. manipulating equipment
5. playing alone or in groups
6. successfully completing an activity

Adults facilitate learning by providing opportunities for children to try out new solutions and allowing children to hone their skills through practice and repetition of favorite activities.

Stimulating Physical Development

Gross motor skills refers to the ability to use the large muscles of the body, the arms, legs and torso to control body movement such as bending, walking and throwing, jumping, running, hopping.

Fine motor skills generally refers to actions of the hands, wrists, and arms, including dexterity, coordination, and strength. These actions can be broken down into six components: basic reach, grasp, carry, release, in-hand manipulation and bilateral hand use. Fine motor skills enable people to do many things in daily life without even realizing the complexity of what the hands and arms are doing.

Children with physical disabilities may require individualized programs developed by physical and occupational therapists.

Adaptations and Modifications for Preschool Children with Special Needs

Refer participants to Handout 14 – Adaptations and Modifications

Inclusion brings young children with special needs to child care centers, preschool programs, Head Start programs, and family child care. For children with special needs, many typical experiences need to be modified to promote their development.

All children need nurturing and an environment that stimulates learning, but for children with special needs, many typical experiences need to be modified to promote development. Changes in the curriculum and environment can make an unsuccessful activity into a successful experience for children with special needs.

Keep directions simple
Break the task into progressive steps and demonstrate each task
Use frequent praise and encouragement (verbal and nonverbal)
Repeat directions often
Guide the child through the activity – model
Use one-step directions
Select activities that focus on concrete themes and processes
Alternate quiet activities with active activities
Give physical and verbal prompting as needed
Make sure you have the child's attention/that he or she is looking at you before instructions are given
Provide individual and small group instructions
Establish and maintain routines
Provide visual cues with auditory

Children with developmental delays need a longer time to move through transitions, extra cues and assistance.

For the child with limited language skills, putting on outdoor clothing might signal the time to go home instead of time for outdoor play, or vice versa. Use picture cues to help the child understand the nature of the transition. For instance, a picture of a school bus or a mini-van means time to go home while a picture of the playground or a piece of outdoor playground equipment means it is time to go outside to play.

Here are some tricks for teaching a child how to get a jacket on independently: (1) Place the open jacket on the floor or table with the collar end of the jacket next to the child. Show the child how to slide her arms into the sleeves and then flip the jacket over her head. (2) Leave the jacket zipped up part way so that the child can step into the jacket. (3) Hang the jacket from a clothesline with two clothespins. Have the child back into the jacket and place arms in sleeves. Then as the child walks forward, he/she will pull the jacket off the line. (4) Place the open jacket on a child's chair and have the child sit on

the chair. Prompt the child to place one arm into a sleeve, assisting as necessary. Repeat for the other arm.

To help children stay in line when walking from one location to another, have them hold onto a rope that has been marked with strips of colored tape at two-foot (sixty-centimeter) intervals.

Children with Physical Impairments and Motor Delays

The child with orthopedic impairments frequently requires assistance to move from place to place.

Let the child use a coat hook and cubby that are located at one end of the row of cubbies, rather than in the middle. This location gives the child more space without getting in the way of other children who are also at their cubbies.

Some children with mild orthopedic impairments prefer sitting on the floor or on a child-size chair for dressing tasks. Other children benefit from additional support in the form of a beanbag chair, a corner seat, or cushions placed around the back and sides.

Because some children with orthopedic impairments can't move out of play centers independently, they end up staying in only one center, even though they are actually finished playing. Give the child frequent choices so he/she can let you know when he/she is ready to transition to another center, or provide the child with some way of communicating to you that assistance is needed to move to next play area.

Encourage children to verbalize where they are going when transitioning from one center to the next. Talking about the sequence of the activity beforehand sometimes helps the child with motor planning issues to form a mental image of how his/her body needs to move in order to get to the next activity.

Make sure traffic paths are cleared of clutter so that the child doesn't have to negotiate around extraneous obstacles.

Once a child arrives in the next center, encourage the child to verbally describe his/her plan of action: what he/she is going to do and how he/she is going to do it. Verbalizing helps the child organize and plan. Also use this intervention during dressing and undressing activities.

Make sure adaptive materials are available. Use wider pencils for hand grips, squeeze scissors, large containers for paint or paste, slip store-bought foam hair curlers over pencils and brushes, apply Velcro® dots or strips to brush handles, and use shaving brushes, deodorant roll-on applicators or sponges for painting.

Stabilize objects in the workspace by using trays, taping down paper to table or easel, and putting heavy objects in the water cups to prevent tipping.

Pad the edges and backs of shelves and tables to prevent children who bump into them from getting hurt.

Ask before providing assistance and when assistance is required, provide only the amount that is needed.

Design activities with plenty of extra time for slower-performers.

Provide enough space for movement activities for a time when the child has a lot of energy.

Consider any safety precautions before selecting an activity. If the safety of the child is questionable, do not use the activity.

Do not use items that are too small or difficult to pick up. If the activity requires the child to pick up an art material, put the materials in a tube and let the child sprinkle them onto the pasted paper.

Start with larger objects and move to smaller ones.

Encourage children to attempt buttons, zippers and snaps, giving them only as much assistance as needed.

Make sure activities are of interest to the child to capture the child's attention. Include some of the following tasks in your fine motor centers: snipping paper of various thickness, snaps, buttons, zippers, pushing small items through slits made in the plastic lids of containers, dressing and undressing dolls, washing doll clothes and hanging them on a line to dry, woodworking, hammering, sanding, and planting seeds.

Encourage activities that will develop the child's body concept such as large movement games that include rolling, crawling, walking backwards and sideways, jumping, and other movement variations.

Provide a non-slip surface by placing rubbery shelving material or a piece of rug mat on the table.

Stabilize the base of a fine motor activity by taping or clamping it to the table.

Allow success that is visual to the child by modifying activities. (For example: superimpose colored marker segments over the line that is to be cut. For instance, the first segment could be purple, then red, blue, and green. The child will now view this activity as a series of attainable short steps, rather than one large, overwhelming project.)

Children with Communication Disorders

Be a good verbal role model by speaking in complete sentences. To increase articulation and language skills, talk while doing simple tasks.

Repeat, with corrections if necessary, what a child has said. However, do so by restating what the child has said rather than correcting him or her.

Reward the child for efforts to communicate.

Reward the child for efforts to use speech.

Attend to what the child is saying rather than how it is said.

Ask the child questions, preferably open-ended ones, to encourage language and expression.

Encourage spontaneous speech.

Use props that stimulate language.

Use short, concise statements.

Simplify tasks by reducing the number of steps.

Simplify the language that you use with the child.

Maintain eye contact with the child when speaking.

Model language using the pronoun "I".

Work one-on-one with children who are having difficulty with communicating.

Encourage children with delayed language to say at least a word or two. Repeat their thoughts in a full sentence with correct pronunciation.

Children with Hearing Impairments

Look directly at the child to whom you are speaking. Speak slowly as the child may wish to lip-read.

Be flexible with your language. If a word is not understood, try another word rather than simply repeating yourself.

Be aware of your interpretations of the child's attempt to communicate (a nod of the head does not necessarily mean "I understand").

Speak in a normal voice, do not shout. Hearing aids make sounds louder, not clearer.

Check with the child's special education specialist to ascertain if it is appropriate to use sign language, miming, or gesturing to augment lip reading abilities.

If you are talking to someone who is a lip-reader, keep the following things in mind: avoid changing subjects suddenly, keep your face in the light so the person can see your lips and never look away or cover your mouth while speaking.

Use simple, basic language. Do not chew gum while instructing or communicating with the child.

Seat child in a location where sound is clear.

Accompany oral direction with gestures, pictures or objects.

Make oral direction short and simple.

Post a pictorial representation of the day's schedule.

Use transition cards or tickets that have a picture of the next activity.

Check child's hearing aid daily to ensure proper functioning (check with child's speech pathologist or hearing specialist for procedures).

Check child's hearing aid periodically throughout the day for proper fit and to ensure that the aid is turned on at appropriate times.

Children with Visual Impairments

Encourage the child to use whatever vision he has.

Mark areas of the room with easily identifiable tactile objects.

Reduce glare. Use shades on windows, but have good, even overhead lighting. Use a dull finish on tabletop surfaces and matte (flat) paint for walls.

Keep noise level in room down and reduce extraneous visual stimuli.

Watch for signs of fatigue: yawning, eye rubbing, blinking, eye rolling, distant gaze.

Work with parents, counselor, psychologist, or vision specialist to set up consistent cues to help reduce inappropriate mannerisms common to blind children (hand waving, flicking fingers in front of eyes, rocking, arm flapping, light gazing, eye poking, eye rubbing).

Use consistent labels for objects. For instance, don't say, "cat" one day and "kitty" the next.

Teach the child consistent routines in the classroom to encourage independence.

Keep the child constructively involved in activities in order to discourage a pattern of repetitive self-stimulatory behaviors.

Encourage gradual exploration of different textures and surfaces.

Tell the child before touching him/her.

Walk in front or next to the child, not behind.

Speak to the child using a normal volume and tone of voice.

Actively assist the child to explore his/her environment. If the child has bumped into or tripped over something, help the child go back and explore the obstacle visually or by touch.

Investigate the source of loud noise or any other stimuli that frighten the child.

Use bright fluorescent colors like red, yellow, pink, and orange in activities or to modify toys to encourage the use of vision.

Do not leave a child with blindness in an open area. Instead lead the child to the side of a room or a landmark from which he can obtain a direction for travel.

Watch positioning to avoid shadows on the visually impaired child.

Enlarge materials as appropriate.

Use big books or large print.

Although some children with visual problems prefer dimmed lighting, most want bright, even lighting. The table surface should have a dull finish on it and be placed in an area of the room where the lighting is optimal to reduce glare and shadows.

Use high-contrast materials, such as dark or bright colors on light paper. Red, yellow, and orange are the easiest colors for a low-vision child to see, especially on a dark blue background.

Place a piece of mesh or screening under the paper when coloring with a crayon so that the child can feel the raised finished product.

To reduce glare from reflection of light, use pastel paper instead of white paper.

The child with visual impairments might need more time than other children to become accustomed to a new school setting and all its transitions. This child might prefer to spend days or even weeks in one play area rather than joining the larger group for activities and transitions in order to gather auditory information about the flow of the day and the scope of activities.

Assign the child a coat hook and cubby at the beginning or end of the row and place a tactile cue just below it.

Instead of a tactile marker for the cubby area, use an auditory marker such as a small bell. Hang the bell just above the child's coat hook.

Give the child verbal information about the location of items in the room.

Accompany all actions with clear, short descriptive statements. "Jill is handing the pine cone to Robert so that he can feel it." This lets the child know what is happening within the group.

Modifications in Centers for Children with Special Needs

Block Center

Place a basket of blocks next to each child or pair of children.

Encourage children to use props such as toy animals and people, cars, and road signs.

Let each child use only a small number of blocks.

Use mats, tape, or other suitable material to define children's spaces.

Let the child lie on a wedge mat while building with blocks on the floor.

Encourage the child to build against a stable surface such as a wall.

Place carpeting in the block center to help reduce noise.

Remind children of block center rules frequently.

Rotate the types of blocks: plastic blocks, unit blocks, large wooden blocks, and cardboard blocks.

Use interlocking blocks such as Bristle Blocks™ or Duplos™.

Encourage block activities that are at the child's developmental level. Filling up a container or dumping them out are legitimate block center activities.

Model imaginative play and provide opportunities for children to imitate your block structures and play.

Encourage children to build horizontally rather than vertically.

Allow children to build inside a large empty appliance box.

Sand and Water Center

Limit the number of children at the sand and water table to two if the children who are present are easily over-stimulated.

Adjust the height of the water table to the child's needs.

Remove wheels or stabilize table against a wall so that the table is not sliding around.

Break down directions into small steps.

Model language concepts such as big/small or full/empty.

Use sand and water play as an opportunity to get the child out of his/her wheelchair and on to his/her tummy to play on a wedge or in a prone stander. Speak to the child's therapist about positioning.

Make sure that there is adequate lighting over the sand and water table if the child has visual impairments.

Replace sand with heavier materials, such as pebbles, if the sand is too over-stimulating.

Put sand in basins to define the child's play space.

Give clear and concise directions to help the child expand play skills.

Provide enough play toys to lessen conflicts between children.

Use brightly colored toys that contrast with the sand.

Change water in the water table daily.

Supplement verbal directions with pictures or signs.

Introduce novel toys if the child's attention begins to fade.

Encourage sharing and interaction with other children.

If the child is anxious about water play, give the child time to observe other children and gradually have the child approach the water table.

Art Center/Writing & Bookmaking

Build up handles of paintbrushes, crayons, and markers.

Place each child's art project inside a shirt box or on a cookie sheet.

Provide a variety of sizes of coloring implements.

Use large paper surfaces taped to the wall or an easel at eye level.

Add thickeners, textures, and fragrances to paints.

Allow children to stand, kneel on a chair, or straddle a chair while playing at the art table. Have stencils of simple geometric shapes available for children to use.

Try alternatives to white glue, such as tape, sticky paper or a glue stick. Place pieces of pre-cut tape along the edge of a weighted container.

Place only one or two collage materials on the table at one time.

Make a tabletop easel out of a cardboard box.

Use high-contrast materials.

Use pastel paper instead of white.

Place paper on top of mesh screening or sandpaper.

Use study carrels to separate work spaces.

Prepare the child's hands with a warm-up clapping activity.

Experience cutting a variety of materials, not just paper.

Tape one end of the paper to the wall for cutting.

Hold the paper for the child while he/she is learning to cut.

Use a variety of scissors, including small scissors, designed for preschoolers (available through catalogs).

Use glue to outline forms for coloring or cutting.

Dramatic Play Center

Let the child choose play that is of interest to him.

Provide direct instruction of play skills when needed.

Teach peer role models to include the child with special needs in play.

Set up boundaries to keep the children close to each other to encourage interaction.

Position children so that they can move to the best of their abilities.

Establish only those rules that are needed for the children to play safely.

Allow some roughhousing to provide children with an opportunity to learn to read the nonverbal cues of the other children.

Encourage children to verbalize their plans for play and to review what they did when the play is over.

Help parents to encourage dramatic play at home.

Create storybooks about the children's play and read frequently as a tool to teach play skills.

Dress-ups should be easy to get on and off.

Provide picture icons to help the child learn new play skills.

Teach children to use language to express feelings and resolve conflicts.

Partition off the dramatic play center by hanging sheets from the ceiling.

Assess the child's play skills by observing how he/she plays.

Avoid interrupting the child's play unless the child needs help to expand play.

While children are playing, stay involved by observing or playing with the children; don't use this as a time to talk to other adults.

If the children in your classroom tend to get over-stimulated, play music with a slow, even beat while the children are in the dramatic play center.

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EARLY CHILDHOOD PARAPROFESSIONAL

BEHAVIOR

SECTION C

Early Childhood Paraprofessional Module

Behavior Section – C

Overview

Knowledge in behavior management techniques and strategies for classrooms and individuals will enable the paraprofessional to assist the supervising teacher to teach behaviors conducive to learning.

As educators our common goal is to teach behaviors that are appropriate just as we teach other subjects. The role of the paraprofessionals should include but may not be limited to assisting the supervising teacher in creating a positive learning environment, observing, recording, and charting behavior, supervising students' behavior during free play and classroom activities and reinforcing appropriate behavior and skills.

Instructional Objectives:

1. The paraprofessional will have the ability to identify behavior management techniques that will benefit all children.
2. The paraprofessional will have the ability to identify behavior management strategies that may be used with individual children with challenging behaviors in classroom/child care settings.

Classroom Techniques

Refer participants to handout 15

A. Structure rooms and activities in a developmentally appropriate way

Children benefit from a stable and organized classroom or child care setting. Minimize physical changes in the classroom and prepare children for them. Children with behavioral issues thrive on routine and structure. Consistent daily routines allow children to know what will happen next. Children should know what to expect, what happens first, next, etc. Reinforce the routine throughout the day by reminding children of the schedule, posting a picture story of the day's events, and spending a few minutes quietly orienting the children to the school day when they first arrive.

Rules should be clear and consistent. Enforce rules consistently, in the same way, using the same language, and for the same reasons. Use short, simple explanations whenever possible, avoiding lectures. Speak to children using a normal tone of voice. If you show irritation, children may become more agitated. Explain rules and expectations before an activity. Use demonstrations to help the children understand and build in reminders of expectations.
- Example: When describing an upcoming field trip, state specific behavioral expectations, "You must stay in your seat on the bus." – During the trip, give

reminders by commenting on correct behavior – "I am glad you are staying in your seat."

Do not take negative behaviors personally. Recognize that children may not know how to act in new situations. Expect appropriate behavior and provide consistent consequences for unacceptable behavior.

The paraprofessional should be aware of the amount of stimulation in the classroom. Some children may respond better with low levels of stimulation. Have a quiet area available in the classroom. It should have very few toys and limited objects hanging on the walls. Some children respond or calm to soft music and the use of headphones. Rather than introducing new play materials all at once, introduce one or two at a time to decrease stimulation.

Children cannot comply if they do not understand what is being asked of them. Keep directions simple. Use one or two related steps. Establish eye contact by getting on the child's level. Keep questions brief and listen attentively to the child. Give verbal and non-verbal recognition to children for effort.

Refer participants to handout 16 for scenarios

Activity 1- Amy

Read the case study and have the paraprofessionals work in their groups to respond to the questions. After 10 minutes or so, share responses with the entire group, ensuring that the topics in the notes are brought up as ideas to consider.

Scenario: Amy is a fussy, 5 month old baby. When awake, she rarely stays quiet for long unless she is held. She settles for a little while if she is fed, but this has led to frequent, small feedings. Her crying is irritating, so frequently staff take turns carrying her around while they attend to chores and other infants.

> What might you consider when evaluating Amy's behavior?
> 1. Level of stimulation – too much, too little?
> 2. Vicious cycle of feeding whenever a baby cries, when hunger is not the cause, leading to frequent feedings as an infant takes a small amount and is soon hungry again.
> 3. The baby is not learning self-quieting skills. How might these skills be taught?
>
> Does Amy always get attention when fussing, but not when quiet?
> From whom might you get information and with whom would you share your plan?

In order to structure rooms and activities in a developmentally appropriate way the paraprofessional should learn the developmental level (the child's developing skills,

abilities, and limitations) of each child. Activities should meet the child's developmental level, especially each child with special needs.

It is important to remember that behavior is influenced by a child's developmental level. For example: children who have trouble using or understanding language often have trouble following directions. They may hit, cry or bite instead of using language to express their feelings.

B. Positive reinforcement

All behavior is started, maintained, strengthened, or weakened by the consequences that follow it. Positive consequences (rewards or positive reinforcers) increase the likelihood that the behavior will be repeated.

Basic principles

1. Behaviors that are followed by positive reinforcers (rewards) tend to increase in strength or frequency.
2. An appropriate and an inappropriate behavior cannot be emitted at the same time – these behaviors are considered competing. Example: Tommy cannot be playing appropriately with his friends and be hitting them at the same time.
3. If the child's good behavior is strengthened through reward, the child is less likely to misbehave.

To use reinforcers effectively the paraprofessional should reward good behavior immediately each time it occurs. The reward must be meaningful to the child (Is the reward something that makes the child feel good?). The paraprofessional should find out what works for each child, as what works for one child may not work for another.   When working with a behavior it must be specific enough that someone else could observe it and reinforce the child. When starting to address a behavior do not expect perfection the first few times. Reward small steps in the right direction, reward improvements. After a behavior becomes strong begin to reward intermittently to keep it going for a long time. Have a plan for reducing the frequency of reinforcement. The first time you skip reinforcing a behavior, it is important to ensure that the child gets reinforced the next time the behavior occurs.

There is no formula of reinforcers that works the same way with every child. However, intrinsic satisfaction (feeling good about oneself) is a powerful reinforcer, and is more motivating than tangible rewards such as stickers or other prizes. Praise promotes good feelings about oneself and is one of the most powerful ways of influencing a child's behavior. Praise has the most power when it helps a child feel proud of him/herself rather than just complying with authority. When the paraprofessional sees a child doing something wanted, praise the child – catch him/her being good.   Be consistent in attending to and praising appropriate behaviors, even when the children are behaving well.

Activity 8 – Michael

Read the case study and have the paraprofessionals work in their groups to respond to the questions. After 10 minutes or so, share responses with the entire group, ensuring that the topics in the notes are brought up as ideas to consider.

Scenario: Michael is a 4 year old with significant developmental delays; including delays in language, cognitive, and motor skills. Michael is having a hard time adjusting to classroom rules. He is active and does not stay with tasks for any length of time. He is aggressive toward other children and sometimes towards adults (hitting and kicking).

What might you consider when evaluating Michael's behavior?
1. Safety. Are the caregivers able to keep Michael and the other children safe?
2. Michael's developmental delays contribute to his behavior.
3. Try to determine when Michael is most likely to behave aggressively.
4. Identify Michael's strengths.

What adjustments to the classroom environment might be considered?
1. Structure and consistency are important for Michael. Expect Michael to need extra help during transitions.
2. Make sure Michael has developmentally appropriate play materials available.
3. Michael may do better playing with just one or two other children.
4. Catch him being good.

How might the caregiver deal with Michael's hitting?

Effective praise is:
1. Specific
2. Immediately follows the desired behavior
3. Is sincere

Example: I see you are sharing the markers with Erica. That's nice. I bet that makes her happy."

Activity 9 Handout 17 Positive Words

In table groups change each negative statement to a positive statement. About 10 minutes for this activity, then tables share how they changed verbally.

C. Transitions between activities (Handout 15 for note taking)

Having transitions between activities are important for good behavior management in the classroom. Transitions will be easier if children understand your expectations. Rituals,

or particular ways of doing things, help children understand what you expect. For example, a lunch time ritual may consist of putting toys away, sitting in a circle to sing a song, washing hands and then sitting to eat lunch.

Paraprofessionals should provide warnings to prepare children for the next activity. For example: use an end of play time song before a clean-up song. Transition times should be brief. Long waits may cause misbehavior. Incorporate activities into transitions, keeping children busy. Activities could include singing a song, imitating movements or facial expressions, or pretending to be a robot or elephant.

To assist children who have difficulty with transitions the paraprofessional may want to have the child start earlier than the others with transition activities. Providing a picture schedule of the day's activities in combination with verbal prompts may assist the child to transition more easily. Bringing the children back to the circle time or rug area between activities for a few minutes may reduce resistance to transition. Providing the child with an object or task may aid in transition (If a child does not want to transition from blocks to housekeeping, get a toy from the housekeeping center for the child to hold during the transition).

Paraprofessionals should always try to have the next activity ready in order to reduce wait time. Excessive waiting is frequently the time that children become restless and aggressive. The paraprofessional should have alternative activities or approaches planned to assist in eliminating transition concerns.

D. Help the child feel part of the group

To increase children's desire to work with the group the paraprofessional needs to help the children feel safe and secure. If the children feel safe and secure they will be more willing to try new challenges. The paraprofessional should encourage "family" or "community" so that the children develop emotional attachments to each other and to care givers, teachers, school and their community. Providing children with clear, short descriptive statements with the action taking place helps children to know what is happening within the group. Example: "Jill is handing the pine cone to Robert so that he can feel it."

E. Other ways to avoid problems

1. Analyze situations where behavior problems are seen to determine how the activity could be changed to avoid the problems. Example: are children left waiting too long without something to occupy them? Keep children busily engaged in activities. Provide children with activities in which they may channel their energies in a positive way. Identify each child's individual space, and provide ample physical space. For example, use tape or carpet squares. Provide children with containers to obtain or return multi-pieces to a shelf or box (a basket to carry blocks to and from the shelf). Some children need physical differences, allow children to hold a stuffed animal or ball during activities that require them

to be still. If a child can not seem to sit still, do a gross motor activity before expecting the child to sit still. Allow children to stand or sit in their preferred position during activities being performed at the table (cutting or coloring).

2. Provide children with reasonable choices. Do not phrase instructions (orders) as if the child has a choice when there is no choice. That is, do not say "Do you want to pick up your toys now?" Say "It is time to pick up your toys." Offer children limited choices rather than free choice. Offering limited choices restricts the possible responses, where a free choice may lead to the child making undesirable choices. An example might be, "Do you want peanut butter or jelly on your toast?" instead of "What do you want on your toast?" The paraprofessional should offer choices that are acceptable, but gives the child the sense that he/she is in control. (Example: Do you want blue or white paper?)

3. Respect the child & his/her feelings. A child's self-concept, the way one thinks about oneself, affects behavior. Help children to express emotions in appropriate ways. Do not ridicule or embarrass a child. Avoid compliments that also express criticism such as, "You shared nicely today. Why can't you always share the toys that way?"

F. Teach self-regulation as part of the curriculum

Children need to be aware of their own behaviors. Paraprofessionals should recognize and acknowledge the child's feelings while helping him/her express them in an acceptable way. To assist in development of self-regulation paraprofessionals should help the child identify and talk about feelings. Ask open ended questions to encourage communication. At first, paraprofessionals my need to provide "feeling" words for the child, the child will learn to use these words with practice.

A part of teaching young children self-regulation is intervening when behaviors begin to escalate to uncontrollable levels. The paraprofessional should help the child bring his or her behavior back to a level that he/she can control. When a child needs a place to regain control, provide a spot that feels neither rewarding nor punishing. Provide the child with a few positive things to interact with while calming down. An example might be: providing a book to look at in the calm area. When the child feels more comfortable, he/she should be able to return to the group without consequences. Paraprofessionals may want to practice this with children before it is needed.

When children fight, separate them and help them discuss better ways to respect each other and resolve differences. Paraprofessionals should remember, do not lecture, speak to the children using a normal voice tone, if you show irritation, the child will become more agitated.

Teach problem solving skills for social situations. For example: young children can't easily interpret whether another child has intentionally or accidentally touched or bumped into them and may hit the child in response. Discuss with children the appropriate way to interact when this happens and allow children to practice.

Refer participants to Handout 18

1. Observe, Identify and Describe Behavior

Management of behavior requires that the paraprofessional be able to observe, identify, and describe behavior. To observe, identify and describe behavior the paraprofessional should learn each child's strengths and limitations. Learn which behaviors a child is capable of changing. Do not punish children for behaviors they cannot control. Instead, change the way the behavior is viewed. Determine whether the desired behavior is within the child's physical or intellectual stage of developmental ability. (e.g., toilet training) Some behaviors may not be worth worrying about or are best ignored or just understood, perhaps the behavior is developmentally normal, so pick your battles wisely.

The paraprofessional should determine when the problem behavior is occurring. Look at the time of day, what is the child doing immediately before and after a behavior, how is the behavior responded to (by you and the other children), how often does the behavior occur, and how long has the behavior been a problem? Try to determine what is prompting the or provoking the behavior. There is a reason for behavior. A child's behavior is telling you something; it is a means of communicating.
In some cases, the best way to change a behavior is by eliminating the reason behind the behavior. Look at the classroom environment and determine if a change can be made that will alter the behavior. For example: allowing children to hold a stuffed animal during activities that require them to be still is an easy step to take to keep the one child who is having difficulty moderating his/her activity level.

One of the most important things to remember is to determine whether the child understands that the behavior is unacceptable. Young children need to be told and shown which behaviors are desired and which are unacceptable. For example: To ensure that children know when they need to stop and activity and listen to you, teach them a key phrase: "Stop, Look, and Listen" – when children hear you say this they learn to stop talking, cease all physical activity, and look at you for directions. Paraprofessionals need to identify the desired behavior, but you may need to have an alternative behavior based on the developmental readiness of the children. It is also important to expect appropriate behavior and provide consistent consequences for unacceptable behavior.

2. Ignoring and Extinguishing Behavior

Ignoring and extinguishing can be a useful strategy. Ignoring a behavior is to not recognize it, to pay no attention to the behavior. Extinction is weakening a behavior by removing the consequences that have supported it. For example, if your attention has consistently followed a student's out of seat behavior, and you withhold attention each time the child is out of seat, the behavior will become weakened over time. When the child stops the inappropriate behavior (sits in seat) then the paraprofessional should give

positive attention to the appropriate behavior, to include: hugs, smiles, praise or reward. It is important to note that dangerous or destructive behaviors cannot be ignored, and the paraprofessional needs to stop the dangerous or destructive behavior. Stopping the behavior can be accomplished with redirection.

3. Redirection

Redirection is replacing an inappropriate form of an activity with an appropriate form of the same activity. For example, coloring on the wall with a marker is not permitted. The activity may be redirected to an appropriate form of the activity by giving the child a piece of paper on which to color. Another way to redirect this activity would be to replace the marker with a dry, soft paint brush and permit the child to pretend to paint on the wall.

When we provide an alternative activity the paraprofessional should state what the child needs to do rather than what you want the child to not do. For example, say, "Put the blocks on the shelf", rather than, "Do not throw the blocks in the box." After redirecting a child's activity/behavior, positively reinforce the accepted behavior (praise or reward).

Redirection may not solve the problem the first time it is used, especially with very young children, who need to test rules to see if they hold true under different circumstances. For example, it is not okay to color on the wall, but it may be okay to color on the door. The paraprofessional should be calm, firm and persistent when using redirection. The behavior that is repeated or the "testing" that the child is doing is a sign of curiosity and thinking ability rather than deliberate disobedience.

Activity 10 – Billy

Read the case study and have the paraprofessionals work in their groups to respond to the questions. After 10 minutes or so, share responses with the entire group, ensuring that the topics in the notes are brought up as ideas to consider.

Scenario: Billy is a 4 year old who simply will not stay on his blanket and sleep during nap time. He is either talking to the child next to him, banging his feet or on the floor, asking to get a drink, or sneaking off toward the toys. The caregivers must constantly keep an eye on him and tell him to "Lie down and be quiet."

1. What might be the initial cause of Billy's unwillingness to nap?
   Possible factors: not tired, easily stimulated/distracted

2. How might you assess this?

3. How much attention does Billy get during nap time?

4. Develop a plan(s) to handle the problem.

The plan should incorporate decreasing the factors that may be leading to the problem and redirection.

4. Setting Limits

Setting limits clarifies for the child both the desired behavior and the consequences of failure to cooperate. The paraprofessional should use limits when the child's behavior is inappropriate or dangerous. When using this strategy the paraprofessional should remain calm, using a normal voice tone, clearly state the rules. Tell the child what to do instead of the behavior being demonstrated, and what will happen if the request is ignored. The paraprofessional should assist the child with compliance through physical intervention to help the child comply with the request. The paraprofessional should avoid repeating a request or command as this teaches the child that compliance is not expected until after the second or third request. If the child does not comply after the first request, assist compliance, offering only those choices and consequences you are willing and able to implement.

Activity 11 – Joshua

Read the case study and have the paraprofessionals work in their groups to respond to the questions. After 10 minutes or so, share responses with the entire group, ensuring that the topics in the notes are brought up as ideas to consider.

Scenario: Joshua, 2 years old, is playing on the floor with a puzzle, trying to put it together. He is having some trouble getting the pieces to fit and is pushing on them harder and harder with accompanying grunts and small shrieks. Another child squats down and picks up one of the puzzle pieces. Joshua screams, tries to grab the pieces, hits the other child and pushed him.

1. What happened here?
2. What are some things the caregiver(s) can do after Joshua hits the other child?
3. When and how could an adult have intervened to avoid the situation?

5. Use Natural and Logical Consequences Whenever Possible

Natural consequences are the inevitable results of the child's own actions. For example, if a child does not eat lunch, he will be hungry at snack time. Permit children to be responsible for their own actions rather than protecting them by providing consequences for them.

Logical consequences follow from the child's actions but involve caregiver intervention. For example, a logical consequence of a child continuing to throw sand at another child, after a reminder not to, could be removal of the child from the sand and requiring him/her to change activities. In order for the consequence to be logical it needs to be consistently applied each time the "problem" occurs, should be logically related to the event, and must be an acceptable alternative to the paraprofessional/caregiver.

6. Shaping

Shaping is the reinforcement of closer and closer approximations to the desired behavior. Shaping can be used to teach a new skill or to improve on that already exists. Some skills are so complicated that young children are not capable of making the complete change or learning the whole skill in one step. Shaping breaks down the skill into smaller, more manageable steps.

When using shaping there are logical steps to follow. Assess the behavior or skill to be mastered and develop a plan that breaks it down into small steps. Reward the child for success with each step. As the child progresses from step to step, the reinforcer for the previous step may be eliminated. The implication here is that only steps closer to the desired behavior are rewarded. Keeping a record or time checklist to note the gradual pattern of behavior change will assist the paraprofessional to communicate in a positive way with a child's parents/guardians. For example, "Johnny only hit once today. Last week he was hitting at least 3 times each day. He is getting better at handling frustration."

Changing behavior takes time. It is best to work on changing one behavior at a time. Expect set-backs. A child may master a step one day and forget it the next. In addition, there may be an increase in an undesirable behavior when it is first addressed; but then the undesirable behavior will gradually decrease while the desired behavior will gradually increase.

7. Stay in Charge

The paraprofessional should be patient and maintain leadership of the interaction with the child. The paraprofessional should be prepared. Have a plan for what you expect and what your response will be to inappropriate behaviors such as biting, hitting, or failure to cooperate. By having a plan you will respond consistently and probably more wisely.

Refer participants to Handout 19

Stay in Charge Checklist

1. Avoid conflict situations, they usually lead to escalating power struggles
2. Firmness does not require anger. Expressing anger may help you get rid of your own tension, but it does not teach the child what you think he/she should learn. Intervening earlier in the behavior, before you feel anger, may be helpful.
3. Lectures and arguments with children rarely accomplish what you intend. Respond to what the child does, not to what the child says. State simply and calmly what the problem is and what the child must do.

4. Initially when a child exhibits challenging behaviors, you need to take responsibility for your behavior and the behavior of the child. One way in which you can take responsibility for the child's behavior is to guide him/her toward a solution.
5. Take leadership in discussions with the child regarding challenging interactions. Discuss and model better ways to handle the interaction.
6. When using punishment, remember that punishment focuses the child's attention on your behavior, not the child's own behavior. You run the risk of having the child avoid you, and of encouraging the child to be aggressive and punishing toward others.

8. Avoid Blaming

The paraprofessional should be aware that a child is not his/her actions. That is, the child is not "bad" because the child behaves in ways other than those you or others think he/she should. Label the action and/or your feelings, not the child. If you feel the child has made the wrong choice, focus the child's attention and yours on the correct choice.

Do not expect perfection of any child, particularly of a child facing other challenges, such as medical, physical, or behavioral challenges. What may appear to be misbehavior may really be the child's way of communicating something about his/her understanding of the interaction.

Management of Behavior: Adaptations for Infants and Toddlers

1. Infants

The paraprofessional should provide responsive care of basic needs. Anticipate needs and act before an infant cries so the infant does not learn she/he must cry to have needs met. The paraprofessional should recognize each individual infant's temperament and how the caretaking environment may be modified to best meet that infant's needs while maintaining the daily routine.

Stimulation should be appropriate in kind and amount. An infant who has nothing interesting to look at or appealing to play with will be fussy. Likewise, when there is too much stimulation, the infant is overwhelmed, cannot choose one thing to focus on and is fussy. Learn signs of over-stimulation. Infants often "shut-down" or become non-responsive as well as cry.

The paraprofessional should give lots of brief physical contact that gives attention without stopping the infant's engagement in a quiet activity. Infants have short attention spans. Many inappropriate or disruptive behaviors can be handled by interrupting or distracting the child. When interrupting one behavior, offer an alternative. The adult needs to be responsible for an infant's behavior. Interactions are opportunities to teach and encourage desired behaviors.

2. Toddlers

Often, toddler misbehavior is a response to frustration. Try to respond to building frustration before it results in aggressive behavior. This does not mean eliminating challenges, but to provide structured activities which allow the toddler to experience success and feeling competent.

Rules need to be simple, specific, and consistent. Catch the child being good, give attention and reward good behavior without distracting the child from an appropriate activity. Use the toddler's short attention span and curious nature to your advantage, head off trouble before it starts by distracting, interrupting or redirecting.

If a child needs to regain control, move the child briefly to a quiet spot within your sight. When bringing the child back, or if he/she calmly returns, make no mention of the prior behavior and let the child start with a clean slate. If a behavior is not dangerous or causing a real problem, it may best be handled by just ignoring it.

Refer participants to Handout 19

Points to Remember

Changing a child's behavior is not easy and takes time and patience. There are no quick fixes and no one "trick" that works for every child. However, there are general techniques that will benefit all children, and will especially benefit children with special needs.

If what you are doing is not working, try something different instead of trying the same harder. Ask for another adult's input. It is easy for caregivers, teachers, or parents to get caught in a vicious cycle with a child and be unable to see the pattern of what is happening. Another adult's observations and insight may help you see how to interrupt the cycle.

Expect to make mistakes. We all do. Learn from them and maintain healthy, positive leadership in your interactions with children.

Staff needs to support each other. Working with children with behavior problems results in a high burn-out rate for staff. It is extremely important that paraprofessionals and teachers have time to meet with each other to share experiences and find ways to support each other.

Sometimes a child who presents challenging behaviors will require more one-to-one interaction than can be accommodated within typical staffing ratios. When this occurs tap community resources to seek another person to help meet such needs. Such resources may include community mental health services, child care resources and referral agencies, senior citizen programs and religious organizations.

*Taken from "Handbook for the Care of Infants and Toddlers with Disabilities and Chronic Conditions" University of Colorado Health and Sciences Center School of Nursing.

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