Teaching children with diverse impairments and production of didactical materials

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Introduction to this manual

This fourth manual comprises four main parts:

- multiple impairments and the production of didactical materials
- autism and hyperactivity
- deaf-blindness
- social, emotional and behavioral disorders.

In each part, teachers can find key information about identifying these impairments and disorders, their causes, and practical advice for working more effectively with children with special educational needs.

Within the manual there are activity questions to help the reader reflect on what they have learned in previous units. The manual will provide trainees with knowledge to help them teach children with a combination of diverse impairments, with autism and attention deficit hyperactivity disorders, those who are deaf-blind, and some who experience social, emotional and behavioral problems.

As with previous manuals, trainers are encouraged to follow a participative and practical approach when covering the content with trainees. Specifically, trainees are expected to have a practical lesson on how to make and use local, easy, simple and less expensive educational materials.

We wish you a result-oriented, collaborative and active training!
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What is in this manual?

This manual attempts to define and explain some of the terminology used in special needs education, and create awareness among teachers who want to know more about working with children with multiple impairments, autism, hyperactivity and social, emotional and behavioural disorders.

In addition, it is giving highlight on some of the methods and techniques used to make local, easy, simple and less expensive educational materials in a bid to meet the learners’ needs and concretize the teaching/learning process.

Aims and objectives

After reading this manual, trainees are expected to be able to:

- Identify children with multiple impairments, autism, hyperactivity and those with social, behavioural and emotional disorders;
- Identify causes of multiple impairments, autism, hyperactivity and those with social, behavioural and emotional disorders;
- Handle effectively children with multiple impairments, autism, hyperactivity and those with social, behavioural and emotional disorders in an inclusive classroom;
- Produce local, simple, easy and less expensive educational materials.

Part one: Teaching children with multiple impairments

Unit 1: Multiple impairments

This group of impairments refers to children who have a combination of auditory, visual, physical, intellectual and/or behavioral disorders, etc. These combined impairments present complex problems in areas such as communication, motor, language, concept development and self-help skills.

Characteristics of multiple impairments

The main characteristics are:

- stress
- crying
The infant with severe vision and hearing difficulties often experiences very limited interaction, because adults are uncertain about handling such unresponsive children.

Classification

Unit one: Children with learning disabilities

A learning disability is a neurological disorder that affects one or more of the basic psychological processes involved in understanding or in using spoken or written language. The disability may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or to do mathematical calculations.

Learning disabilities should not be confused with learning problems which are primarily the result of visual or hearing impairments, physical or intellectual impairments, emotional disturbance or environmental, cultural or economic disadvantages.

N.B. Please read more details on this topic in the 3rd manual.

Levels of impairment

The main degrees of impairments are:

- mild
- Moderate
- severe

Unit 2: Gifted, genius and talented children

Gifted children are those who have superior general ability in academic performance. Their superior ability is a problem which must be addressed. Genius children excel in almost all academic domains and with less effort. Talented children are those who show signs of special aptitude or ability in specific areas of the arts, sciences, business, etc. (Gagne, 1985)

Renzulli (1985) suggests that giftedness also includes high levels of task commitment, motivation and creativity.
Van-Tassel (1979) proposed the following list of educational inputs for gifted, genius and talented children. These children need:

- to be challenged to operate mentally and effectively at a complex level of thought and feeling
- to be challenged through opportunities of production
- to be challenged by discussions among intellectual peers
- to be challenged through work that demonstrates process/product outcomes
- to be challenged by experiences which promote understanding of human value systems
- to be challenged by the opportunity to see inter-relationships in all bodies of knowledge
- to be challenged by a special course that accelerates pace and depth
- to be challenged by tying abilities to real problems
- to be taught critical thinking, creative thinking, research, problem solving, coping with exceptionality, decision making and leadership.

**Unit 3: Causes of multiple impairments**

There are many causes of multiple impairments, the common ones are:

- meningitis
- cerebral malaria
- cerebral palsy
- measles
- polio
- Down's syndrome.

N.B. Please read more details in the first manual.

**Meningitis**

Meningitis is inflammation (swelling) of fluid which covers the brain and spinal cord. This rise in fluid level is caused by the presence of bacteria virus or toxins in the fluid.

Symptoms:
- fever
- raised pulse rate
- the child is generally not well
- vomiting and shivering
- dizziness
- coma (unconsciousness).

Prevention:
- vaccination
- isolating affected people.

**Cerebral malaria**
This is the form of malaria that affects the brain. It is caused by malaria parasites which enter the brain and attack the brain cells.

Symptoms:
- severe headache (forehead)
- vomiting, fever, pain in the stomach
- loss of appetite
- confusion, unclear language
- loss of consciousness.

Prevention:
- mosquito control
- immediate treatment
- good nutrition.

Cerebral palsy

Cerebral palsy results from damage to parts of the brain. It is characterized by disturbed movements and body balance.

Causes:
- pre-natal infection of the pregnant mother
- peri-natal causes: lack of oxygen (anoxia) during/at birth; birth injury
- post-natal causes: high fever; infection of the brain.

Symptoms:
- unable to walk because muscles are stiff
- emitting saliva from the mouth
- stiff fingers.

Measles

This is a disease with rapid onset and which spreads from child to child. It is caused by a virus found in the nose and mouth.

Symptoms develop in two stages:

1st stage: fever at 39 degrees centigrade, coughing, sneezing, runny nose, followed by bronchitis and conjunctivitis; the child is generally miserable.

2nd stage: severe conjunctivitis and corneal ulcers that could lead to blindness; otitis media (inflammation of the middle ear) may lead to deafness; the whole brain may be inflamed.

Prevention:
- vaccination.
Polio

Polio is an infectious disease which affects the peripheral nervous system, causing floppy paralysis of muscles. Polio is caused by a virus found in the feces and intestines, mainly in the tropical regions of the world.

Symptoms:
- Before paralysis: The child may have a headache, slight cough, fever, sore throat, diarrhea and stiff neck.
- After paralysis: After 1-3 days, the muscles in the body will show paralysis, e.g. the arms, legs, muscles used for swallowing, etc, may be affected.

Prevention:
- vaccination
- general hygiene.

Down’s syndrome

Children with Down’s syndrome are generally slow or delayed in using their mind and body. There is an error in the chromosome or heredity.

Symptoms:
At birth, the child is floppy, weak and does not cry. The child then falls behind in achieving key development stages, such as lifting their head, turning over, sitting, crawling, standing, walking, running and talking. Children with Down’s syndrome also have a distinctive facial shape and features. Their hearing and sight may be affected at a later age.

Prevention:
As Down’s syndrome is a biological disorder, there is no known means of prevention.

Unit 4: Production of educational materials

The production of educational materials ideally should involve promoting and developing locally made materials which will support the learning and teaching process. Educational materials serve different purposes; for instance they can be instructional and provide information, or they can be used to reinforce other aspects of the teaching and learning process.

Instructional methods should vary. At times teachers use methods that are not good for the learners in their classes – their methods may not be interesting, accessible or helpful. Inclusive schools should use teaching and learning methods that encourage learners to be active. Some teaching and learning materials will not suit all learners, so modifications or adjustments to materials are needed to match learners’ needs. Schools need to ensure that a variety of instructional materials are available so that
teachers are able to adapt the curriculum to the diversity of learning needs in their classes.

How to make instructional materials

Instructional materials should support the teacher in achieving their goal for a particular lesson.

The teacher should show:
- What are the materials to be used?
- How to make it
- How to use it
- How to keep and maintain it.

For example: simple abacus.

During this lesson of producing educational materials, trainees are expected to:

- Sensitize their peers on how to make educational materials;
- Make local, less expensive and easy to be used didactical materials by reutilizing objects found in the area;
- Adapt the teaching/learning aids to children’s needs.

How to proceed?
The first step is to know what it is an educational material.

It is a set of objects that support teaching and facilitate the learning process, i.e. manuals, objects, documents, drawn images, cards, maps, audiovisual means, posters, pictures, games, etc. Some materials are posted on the wall; others are used when illustrating lessons. Generally, they help learners to remember what they learnt. Eg. Chart with figures, letters, geographic maps, skeleton chart, etc.
What is an educational material?

It is not difficult to find educational materials around because we are surrounded by different objects and natural facilities: eg. Bottle tops can be used to count, concrete objects, animals, trees, houses, vegetables, radio, equipment of the kitchen, clothes, human beings, etc.

Why to use educational materials?

We use teaching/learning aids to:

- Make the learning process active and productive
- Make the concepts concrete and easy to be transmitted to the learner
- Make orally expressed terms easily perceived
- Make pupils learn through different senses such as visual, tactile, hearing, etc.
- Enhance pupils’ participation, stimulate attention, implication, and respond to slow learners’ needs.
Gihogwe primary school – Gasabo District: Children are learning math using bottle tops.
Trainees are advised to make use of the objects that are in our environment, especially those we use in our everyday life. Therefore, we can make use of them again. Please do never lose them. Among other ones, we can have the following:

- Old containers of biscuits, rice, gums, milk, cheese, etc.
- Metal, plastic boxes (Nido, yaourt, batteries, soaps, etc)
- Small bottles (drugs, juice, beer, etc)
- Envelopes
- News papers
- Jerricans
- Cords, herbs, banana fibers
- Old clothes
- Piece of timber
- Seeds (sorghum, beans, potatoes, avocado, etc) and many others.

N.B. Please think of other objects and make a list.

Within the classroom environment, there are other many educational materials:

- Pencils
- Markers
- Scissors
- Knife
- Ruler
- Glue
- Manila paper
  etc...

N.B. Whenever it is not easy to find glue, we can make it using paste found with cassava powder and boiled water. See an example below:
Locally made glue:

Needs:
- 1 cup of cold water
- ½ cup of cassava powder
- 5 cups of boiled water

Method:

- Mix the cup of cold water with cassava powder;
- Boil 5 cups of water;
- Mix powder with the boiled water and let it on fire at least 3 or 5 minutes.

This glue is contained and conserved in a closed box for One or two days to be used.
Advice

Before making any educational material, remember the following:

- **What material to use and for what purpose?** Ask yourself if it is for Math lesson, social studies, Sciences and elementary technology, manipulation or just to make a joke or fun.

- **For what group of learners?** Remember to adapt the material to the class level. Think of different categories that are in the class, i.e the learners with specials educational needs, disability, vulnerabilities and other realities.

- **Think of the requirements.** Here, you are advised to make a list of what you might require when making an educational material.

General advice

- Be sure of sure of what you are going to make as a learning/teaching aid.
- Be sure that you are capable to conceive, design and draw it before you fabricate. Ask a colleague to help when you hesitate.
- Be confident and creative enough, because everyone can make an educational material.

- Making an educational material is an activity that pleases too much. So make it often to be familiar with learners and get their innovations.
Some illustrations

Fruits and vegetables

Material to use:
Hard paper, manila paper, coloured pencils, markers, scissors

How to make:
Just cut a piece of manila paper and draw the type of fruit you need. Use different colours to make it attractive.

Wall clocks:

Material to use:
Manilla paper, markers, cords, scissors

How to make:
It is an easy exercise. Just imitate the real one that children know.
Musical instruments:

Material to use:
Leather, cords, bottle tops, nail to pin the bottle tops

How to make:
Just shake it and it makes sound. Children beat it depending on the rhythm.

Capital and small letters

Material to use:
Wall cards, cords, markers. A carpenter can help to cut them accordingly.

How to make it:
Children are matching the small letter with its similar capital letter using a cord. It can also be used for children having mobility problems.
Colours/ Using material for construction

Material to use:
Old paint boxes

How to use it:
With these colors, a teacher explains names of colors. It is also easy for learners to manipulate.

Geometric forms

Material to use:
Hard paper, markers, scissors

How to make it:
Just draw a geometric form and cut it to make it tangible to learner.
Quantities

Material to use:
Empty bottles, paint, juice

How to use it:
Use transparent empty bottles (Nile INYANGE, HUYE water) and teach concepts like: “less than”, “equal”, “more than”. Put the bottles in the order and tell pupils to show the big one, the small one, bigger than, etc. Tell him/her to bring the one you need.

Exercise for learners with problems of fine movements

Material to use:
Hard paper, hard paper, pearls, bottle tops, cords

How to use it:
Just use it to count 1 up to 10
Tell learners to come and manipulate to develop his/her abilities to touch.
Representation of figures

Material to use:
Hard paper, marker, manilla, paints, coloured pencil, scissors

How to use it:
Draw them and fix them on the wall in the classroom.

Methods and techniques of making educational materials are different. Teachers have to think broadly according to their teaching and their learners’ needs. The resources are there, we advise teachers to just be creative and active enough to make use of them. It enhances the teaching/learning process by making classes visualized and concretizing the lessons as well. So, thinking that educational materials are only bought is somehow an error, because they can also be locally invented and made. The latter are even more adapted, because they respond to realities.
**Activity 1**
- What are some of the characteristics of a child with multiple impairments?
- What are multiple impairments?
- Why do people with emotional and social problems become aggressive, naughty, hyperactive and demanding?

**Activity 2**
- What is the difference between gifted, genius and talented children?
- List at least 5 challenges you can use to those children.

**Activity 3**
List 6 diseases which can cause multiple impairments and how they can be prevented.

**Practical activity 4**
Think of any other educational material, conceive it and make it. Discuss the use of it with your colleague.
Part 2: Autism and Hyperactivity

Introduction

In this part you will be introduced to the developmental disorders known as autism and hyperactivity.

Aim

to enable teachers to acquire knowledge and skills on the concept of autism and hyperactivity in order to assist learners in their learning process.

Objectives

By the end of this unit you should be able to:

- define the concepts autism and hyperactivity
- identify the causes of autism and hyperactivity
- identify characteristics and associated problems
- explain the effect of autism and hyperactivity on the child’s or learner’s development and learning
- describe educational intervention measures.

This part covers the following:

- definition of autism and hyperactivity
- characteristics of autism and hyperactivity
- problems associated with autism
- possible causes of autism and hyperactivity
- effects of autism and hyperactivity on the child’s development and learning
- intervention approaches.

Unit one: Autism

Autism is a condition generally regarded as being in the most severe group of developmental disorders. It is a neurological disorder characterized by extreme withdrawal from the public. Outset is between 0-5 years. Autism is three times more likely to affect males than females. This gender difference is not unique to autism, since much developmental impairment have a greater male to female ratio.

Most autistic children may be ‘normal’ in appearance, but spend their time engaged in puzzling and disturbing behaviors which are markedly different from other children. Less severe cases may be diagnosed with Pervasive Developmental Disorder (PDD) or with Asperger’s Syndrome. These children typically have normal speech, but have many “autistic” social and behavioral problems.
Many autistic infants are different from birth. Two common characteristics they may exhibit include arching their back away from their caregiver to avoid physical contact, and failing to anticipate being picked up (i.e., becoming limp). As infants, they are often described as either passive or overly agitated babies. A passive baby refers to one who is quiet most of the time making little, if any, demands on his/her parents. An overly agitated baby refers to an infant who cries a great deal, sometimes non-stop, during his/her waking hours. During infancy, many begin to rock and/or bang their head against the crib; but this is not always the case.

In the first few years of life, some autistic toddlers reach developmental milestones, such as talking, crawling, and walking, much earlier than the average child; whereas others are delayed. Approximately, one-half of autistic children develop normally until somewhere between 1.5– and 3 years of age; then autistic symptoms begin to emerge.

For many years autism was rare – occurring in just five children per 10,000 live births. However, since the early 1990s, the rate of autism has increased around the world, with figures as high as 60 per 10,000.

The age of the child when the first intervention is made has a direct impact on the outcome. Typically, the earlier a child's needs are addressed, the better the prognosis will be. In recent years there has been a marked increase in the percentage of children who can attend regular schools and live semi-independently in community settings. However, the majority of autistic persons remain impaired in their ability to communicate and socialize.

One characteristic which is quite common in autism is the individual's 'insistence on sameness'. Many children become overly insistent on routines and may become very upset if the routine changes, even slightly. Some common examples are: drinking and/or eating the same food items at every meal, wearing certain clothing or insisting that others wear the same clothes, and going to school using the same route. One possible reason for this may be the person’s inability to understand and cope with novel situations.

**Causes of autism**

Although there is no known unique cause of autism, there is growing evidence that it can be caused by a variety of problems.

There is some indication of a genetic influence in autism. For example, there is a greater likelihood that monozygotic twins (i.e., identical twins) will both have autism than dizygotic twins (i.e., fraternal twins). Monozygotic twins have a 100% overlap in genes; whereas dizygotic twins have a 50% overlap, the same as in non-twin siblings.

A great deal of research has focused on locating the ‘autism gene’. However, many researchers think that three to five genes will likely be associated with autism. There is also evidence that the genetic link to autism may be a weakened or compromised
immune system. Other research has shown that depression and/or dyslexia are quite common in one or both sides of the family when autism is present.

There is evidence that a virus can cause autism. For instance, there is an increased risk of having an autistic child after exposure to rubella during the first trimester of pregnancy. Cytolomegalo virus has also been associated with autism.

**Characteristics of autism**

- restlessness
- hyperactivity
- severe communication problems
- disturbed language development
- withdrawal (isolation)
- echolalia (repetition)
- behavior and mannerism problems
- self-mutilation behavior (biting, nodding, etc) causing injury to themselves
- lack of daily living skills.

**Problems associated with autistic children are:**

- intellectual impairment
- epilepsy
- physiological problems, e.g. digestion
- perceptual problems
- spinal bifida.

**Educational consideration**

- Develop an individualized program to suit his / her needs
- Build one to one relationship

**Cognition**

“Theory of mind” refers to one’s inability to realize that other people have their own unique point of view about the world. Many autistic people do not realize that others may have different thoughts, plans, and perspectives than their own. For example, a child may be asked to show a photograph of an animal to another child. Rather than turning the picture around to face the other child, the autistic child may, instead, show the back of the photograph. In this example, the autistic child can view the picture but does not realize that the other child has a different perspective or point of view.

About 10% of autistic individuals have special talents in music and art. Another common skill is mathematical ability, for instance calculating complex sums or memorizing large amounts of statistical data.
Many autistic individuals also have a narrow or focused attention span; this has been termed ‘stimulus over selectivity’. Basically, their attention is focused on only one, often irrelevant, aspect of an object. For example, they may focus on the color of a utensil, and ignore other aspects such as the shape. In this case, it may be difficult for a child to discriminate between a fork and a spoon if he/she attends only to the color. Since attention is the first stage in processing information, failure to attend to the relevant aspects of an object or person may limit one’s ability to learn about the objects and people in one’s environment.

**Interventions**

Over the years, families have tried various types of traditional and non-traditional ways to reduce autistic behaviors and to increase appropriate behaviors. Although some individuals are given medications to improve general well-being, no primary drug has been shown to be consistently effective in treating the symptoms of autism. The most widely prescribed medication for autistic children is Ritalin, (a stimulant used to treat Attention Deficit/Hyperactivity Disorder). This drug is not often found in Rwanda, but when there is need of it, it is ordered.

The two treatments which have received the most empirical support are Applied Behavior Analysis (ABA; behavior modification) and the use of vitamin B6 with magnesium supplements.

Behavior modification involves a variety of strategies, (e.g., positive reinforcement, time-out), to increase appropriate behaviors, such as communication and social behavior, and to decrease inappropriate behaviors, such as self-stimulatory and self-injurious behavior.

Vitamin B6 taken with magnesium has been shown to increase general well-being, awareness, and attention in approximately 45% of autistic children. Food intolerances and food sensitivities are beginning to receive attention as possible contributors to autistic behaviors. Many families have observed rather dramatic changes after removing certain food items from their children’s diets.

Many autistic individuals are also sensitive to sounds in their environment. They may hear sounds beyond the normal range and/or certain sounds may be perceived as painful. Auditory integration training, (listening to processed music for ten hours), is an intervention which is often used to reduce these sensitivities.

**Activity**

1. Explain what you understand by the word autism?
2. What are the characteristics of an autistic child?
3. How can you teach the child?
4. You have an autistic child in your class. What measures would you take to help the child learn? Discuss in your group.
Unit 2: Hyperactivity

What is hyperactivity?

Hyperactivity can be described as a physical state in which a person is abnormally and easily excited or exuberant. Strong emotional reactions, impulsive behavior and sometimes a short span of attention are also typical for a hyperactive person. When hyperactivity starts to become a problem for the person or others, it may be classified as a medical disorder.

Causes

- Attention-Deficit Hyperactive Disorder
- puberty
- boredom
- mental conflicts
- problems at home, which may include sexual abuse
- hearing and visual problems
- overactive thyroid
- lead poisoning
- anxiety
- atypical depression
- sleep depression
- a range of psychiatric illnesses
- mania
- effect on children
- learning disability
- difficulty in paying attention in the class
- children exhibit behaviour problems unusual for their age and level of intelligence.

Characteristics of hyperactive children

- seems unable to sit still or to stay seated when expected to
- appears restless and fidgety
- may bounce from one activity to the next
- often tries to do more than one thing at once
- exhibits various characteristics that can be bothersome to teachers, other children and themselves
- runs around or excessively climbs over things
- unduly noisy when playing
- has difficulty engaging in quiet leisure activities
- fidgets with hands, feet or squirms on seat
- shouts out answers before the questions have been completed
- fails to wait in line, or to take turns in games or group situations
interrupts or intrudes on others
- talks excessively without appropriate response to social restraints
- attention difficulties and hyperactivity are pervasive across all their activities
- exhibits the above behavior problems or difficulties both at home and at school.

**Intervention measures**

Intensive sustained special educational programs and behavior therapy can decrease the symptoms and severity of hyperactivity and help children to control their behavior.

Educational approaches include:

- applied behavior analysis
- developmental models
- structured teaching
- social skill therapy
- speech and language therapy
- placement
- environment
- curriculum
- teaching methods and educational materials.

**Applied behaviour analysis**

The teacher identifies the inappropriate behaviour of the student, sets the goal to eliminate the problem behaviour to replace it with more appropriate behaviour.

**Advice:**

- Work with the child to cooperatively identify appropriate goals such as completing homework assignments on time, obeying school safety rules on the school playground;
- Each effort made by the child to improve his behaviour can be reinforced by a tangible reward such as stickers of happy faces or extra time on the computer or playing a favourite game with the teacher.

**Developmental models**

Assign the child a seat near a student role model. This seat arrangement provides opportunity for children to work cooperatively and to learn from their peers in the class.
Structured teaching

Teachers can use special instructional tools to modify classroom learning such as charts with attractive colours, blocks with different shapes and variety of games to suit the special needs of the child. Learning activities should be planned according to the needs of the child.

Social skill therapy

Children should be taught social skills using structured class. For example, you can ask children to role play different solutions to common social problems.

Placement

The hyperactive child can be assigned a seat in front of the class or near the teacher for easy monitoring.

Curriculum

The curriculum should be modified according to the needs and abilities of the child. Lessons should not be too long and should not be difficult for the child to understand.

Teaching methods and educational materials

Teaching methods should be modified according to the needs and abilities of the child. Educational materials should be educative, durable, attractive and easy to handle when in use.

Speech and language therapy

Children should be involved in oral activities like debate, music, reading loudly, role play and indoor games to develop more vocabulary and expression of speech.

The above approaches when applied at an early age in pre-schools can demonstrate effectiveness in enhancing global functioning and improving intellectual performance of young children.
Part 3: Teaching deaf-blind children

Aim

- to enable participants to discuss aspects of understanding and teaching learners who are deafblind.

Outcomes

By the end of the session, participants should be able to:
- identify learners with deafblindness in their classroom
- demonstrate knowledge and skills in teaching learners with deafblindness
- demonstrate positive attitudes towards learners who are deafblind.

Unit 1: Introduction to deaf-blindness

People who are visually impaired often depend more on their hearing (e.g. they will listen for traffic before crossing the road). People who are deaf or hard-of-hearing will rely on their sight (e.g. they might lipread or use sign language to communicate with others). People who are deaf-blind have greater difficulty overcoming these sorts of daily challenges, but with the correct support they are able to. The key to providing that support is communication.

Deafblind people may fall into three groups:

- people with residual sight but who are completely deaf
- people with residual hearing who are completely blind
- people without residual sight or hearing.

Residual sight or hearing is not strong enough for a person to be totally dependent on it. Deafblind learners without any residual sight or hearing need more support than those with residual sight or hearing.

Many people described as deafblind can recognize familiar sounds, might understand some speech, and may be able to speak – especially if they became deafblind later in life. Others have enough sight to see and move around in familiar surroundings, recognize people they know, see people signing if up close, and perhaps read large print. Deafblindness therefore covers a range of impairments with both senses, so every person’s experience of deafblindness is unique.
What is it like to be deafblind?

It is not easy for a sighted and hearing person to understand what it is like to be deafblind. Activities in which participants wear blindfolds and earplugs/ear defenders, and are led around unfamiliar environments and asked to do daily tasks like eating or identifying objects, may help raise awareness of what it is like to be deafblind.

Key difficulties experienced by deaf-blind people include:
- finding out information
- communicating with others
- moving around the environment.

Finding out information

The term ‘information’ covers sources such as newspapers, books, radio and television, as well as information contained in job application forms or supermarket bills. Very often someone who is deafblind cannot access this information. They also face more difficulties finding out information that helps us participate in the daily life of our community, such as the meaning behind facial expressions or the shape of objects that cannot be reached, or the sound of an approaching vehicle.

Communicating with others

People who are deafblind might use one or more ways of communication. Some are based on knowing and using language (including sign language, not just speech); others include simple gestures, facial expressions and movements of the body. Some people who are deafblind may use a form of sign language, e.g. drawing with their finger the shapes of letters on another person’s hand; or using different positions on the person’s fingers and palm to mean different letters of the alphabet. Outside of their immediate friends and family, deafblind people are unlikely to meet many people who can communicate with them straight away.

Moving around the environment

We rely on our sight to move around – avoiding obstacles, planning routes or climbing stairs. Someone who is blind may be able to compensate for lack of sight by using cues such as traffic sounds to know that cars are approaching, and that the bleeping sound means it is safe to cross the road. Sounds coming from washing machines or televisions might help the person to navigate around their house. A deafblind person is not able to use these sounds to help with moving around, especially in unfamiliar surroundings.
Unit 2: How to communicate with deafblind people

Basic interaction – being with the person

Many people who are deafblind are constantly learning about interacting and communicating with others. In every aspect of life they might depend on others, so being with another person can be very important for expressing feelings.

Object of reference

Some people who are deafblind use objects to symbolize or refer to a particular activity (e.g. a fork might indicate that it is lunch-time). Objects of reference can enable people who are deafblind to choose activities, and other people can let them know what is about to happen.

Pictures or symbols

People who are deafblind but have some sight may use pictures or symbols to help with communication. For instance:

*Literacy symbols*
Pictorial Communication System (PCS) symbols

In total these sets provide a vocabulary of over 12,000 concepts and they are used right across the spectrum of age and ability.

Some systems have both signs and symbols.

The really important thing is to remember that everyone is different, with different abilities in spoken and written language, expression, vocabulary, sight, hearing and other individual factors.

Symbols can help support:

- **Communication**: making a symbol communication book can help people make choices.
- **Independence and participation**: symbols aid understanding which can increase involvement, choice and confidence.
- **Creativity and self-expression**: writing letters and stories and expressing your own opinions.
- **Access to information**: all of us need accessible information and this should be presented in such a way that the reader can understand and use.

**Deafblind manual alphabet**

For deafblind people who are fairly good at spelling (usually those who have become deafblind after they acquired language) the manual alphabet can be a quick way to communicate. Using the index finger as a ‘pen’ you point to different finger positions on the deafblind person’s hand, or draw letter shapes.
The deaf-blind manual alphabet is the best way to communicate with someone who is deafblind.

**How do you do it?**
Stick out your index finger (that’s the long one next to your thumb) on your right hand. Fold your other fingers out of the way. Think of this finger as your pen. You are going to use it to write on the deafblind person’s left hand. You need to know the five vowels:

For A, touch the top of your friend’s thumb.
For E, touch the top of their index finger.
For I, touch the top of the middle finger.
For O, touch the top of ‘ring’ finger.
For U, touch the top of the little finger.

For YES, tap twice on your friend’s palm. For NO, (or to cancel what you just said) do a rubbing out movement on your friend’s palm.

**The English Deaf-blind Manual Alphabet (Evans)**
The most comfortable position is for the interpreter to sit on the right of the deafblind person, particularly if the deafblind person can speak. For conversation with someone who cannot speak, the person should sit on the right and at a slight angle, as if seated at a round table.

When standing or walking, the deaf-blind person should usually be on the left, with his/her right hand palm upwards so that he/she can converse and be guided at the same time. When the deafblind person needs to spell, he/she puts his/her right hand over the interpreter’s left hand.

With your forefinger, draw the clear shape of capital letters on the palm of the deafblind person’s hand. Use the whole palm for each letter – keeping them large and clear. Pause slightly at the end of each word making sure the person is able to follow what you are saying. Letters should generally be drawn from left to right and from top to bottom. Letters M N and W should be drawn keeping the finger on the palm and not in separate strokes. Numbers can alternatively be drawn as figures.

**Communicating by using Braille on the hand**

Good braillists may like to use Braille contractions for speed and some will indicate that words/sentences need not be complete because they have a good grasp of language. Braillists may prefer to use dots 4, 5 and 6 for word signs if the deaf-blind person wishes and if the sender knows Braille.

Dot 4 - on the wrist at the base of the thumb.
Dot 5 - on the centre of the wrist in line with the middle finger.
Dot 6 - on the wrist in line with the edge of the little finger.
Dot 4,5,6 - stroke the wrist from under the thumb to under the little finger.
Dot 4,5 - stroke the wrist from its centre to under the thumb.
Dot 5,6 - stroke the wrist from its centre to under the little finger.
Dot 4,6 - touch both edges of the wrist simultaneously.

N.B. Note that these digits are used conventionally as word signs between users.

**Sign language**

Some deafblind people have been deaf from birth but became blind later in life. They prefer to use the sign language used by deaf people. Instead of watching hand and arm movements, they touch the hands of the person making the signs to learn what is being said. It is usually necessary to restrict the movements involved in making signs so that a deaf-blind person can more easily follow them. The speaker needs to be very competent in sign language.

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**Unit 3: Causes of deaf-blindness**

Deaf-blindness is not caused by a single medical condition. People can be born deafblind, possibly as a result of infection, a genetic syndrome or birth trauma. This is often referred to as congenital deafblindness. Acquired deaf-blindness refers to occasions where a person becomes deafblind later in life, for example, as a result of a progressive condition or through infection, accident or the process of ageing.

**Infections**

- Rubella caught during pregnancy used to be a major cause of deafblindness, before the introduction of vaccination programs.
- Other infections which can affect the developing foetus include cytomegalovirus (CMV) or toxoplasmosis. Meningitis is an example of an infection which can cause impairments at any time in life, depending on the strain and severity of the infection. Some particular types of meningitis affect young babies more than other groups.
Genetic conditions

A number of genetic conditions can give rise to deafblindness, for example Usher syndrome. Usher syndrome is due to a gene irregularity which is present from birth, with effects appearing gradually over time. Hearing impairment is usually present from birth or soon after and can range from moderate to profound. Visual impairment is progressive and can occur in late childhood to early adolescence. It is not possible to predict how much sight will be lost.

Birth trauma

Vision and hearing impairment can arise as a result of problems at birth or soon after. Children who are born with such problems usually have additional, often multiple, impairments. They may have severe physical impairment, learning disabilities and communication difficulties.

Accidents or other trauma

Any accident involving head injury can damage the parts of the brain that deal with how we process information through sight and hearing. The injury can have many different effects that are difficult to understand. Other kinds of trauma can result in deafblindness, for instance, a stroke (a cerebral haemorrhage). Again parts of the brain that deal with sight and hearing may be affected.

Ageing

The most common cause of deafblindness is simply age. After the age of around 50 years, hearing and vision impairments become more common.

Unit 4: Methods for teaching children who are deaf-blind

Teaching a deafblind student is very different from teaching a deaf student or a blind student. Deaf students can benefit from sign language interpreters or other visual enhancements in the classroom. Blind students can hear what the teacher says and can take notes in Braille if they have the necessary equipment. Deaf-blind students, however, are unable to use either sense to make up for the other. Unless the student has strong residual sight or hearing, you may need to approach teaching him/her completely differently.
Students with residual sight

Completely deaf students with residual sight may benefit from using large print texts or interpreters. As a teacher, it is important to make sure that the classroom lighting is sufficient, but without glare. Students may also need additional time for written assignments or exams because their limited vision may make it impossible to read at the same pace as their peers.

Students with Residual Hearing

Completely blind students with residual hearing may benefit from listening devices or a microphone to augment the teacher’s voice. They may also benefit from having volunteer readers to help them learn the information in their textbooks, and volunteer note takers who can type up notes in Braille either during or after class so that the student can study. As a teacher of a blind student with residual hearing, it is important to make sure that you speak clearly, face the class while speaking, and do not move around the classroom excessively.

Students without residual sight or hearing

Deafblind students without residual sight or hearing will need a lot more support. From a young age, they may have difficulty learning even the basics in the same time frame as their peers. As a teacher, remember that deafblind children learn from what they do, not from what they hear or see. Before you can teach a deafblind child, you have to gain their trust by keeping them safe and secure. Having a regular routine in your classroom can help to build this trust as well. In general, a deafblind child should be taught individually or with a very small group so that he/she can receive individualized attention. Try to use sensory or kinesthetic teaching whenever possible. In addition, you may want to encourage the deafblind child to learn manual sign language, which gives you a method to communicate with him/her.

Unit 5: Activities to do with deaf-blind children

To get the most out of the activities described below:

- Try to give plenty of time to the activity.
- Try to be as organized as possible before you settle down to play.
- Never leave a child unsupervised.
- Make sure all materials are clean.
- Never use uncooked beans.
- Washable paints are best and absolutely non-toxic.
- Food coloring should not color the skin.
- Choose textures carefully to suit each child.
- If you are using real food, decide beforehand if eating it is OK.
- If a child is unsure, gently encourage but do not force.
- Cleaning up matters. It is best done at the end to avoid distracting the child during the activity.
It is known to be very difficult for congenitally deafblind children to acquire appropriate communication methods and understand concepts of things and events, and therefore construct human relationships.

Activities that attract deafblind children include playing in water, such as water bathing and swimming, and activities which allow one to feel wind blowing or acceleration, such as playing on swings/trampolines and using fans. Popular activities among early deafblind children are those that stimulate a relatively large area of skin.

Everyone needs recreational activities. This is especially important for people with sight and hearing problems as it helps to take away feelings of isolation and dependence. Deafblind children can be taught to enjoy dance and movement. They do, however, require long and careful preparation to reach this point. There may be some participants with total hearing loss who, although not be able to appreciate the music, can still pick up its vibrations. If a dancer holds a balloon it will also pick up the vibrations. Music needs to be played very loud with the bass turned up high.

**Unit 6: Human contact**

Toys can be fun and are often great for educational purposes, but many children who are deafblind or have multiple disabilities are not yet able, or perhaps have not been given an opportunity, to choose toys or activities for themselves. If a child were free to choose any toy at all, he or she would probably choose you, the ‘human toy’. We often forget the two things that are most important to children, especially to children with sensory impairments: effective human contact and interaction.

There is often too much emphasis on teaching children, particularly those with severe physical disabilities, to use toys by directing and controlling their hands and not enough emphasis on personally interacting with children to achieve the same kinds of skill development.

A good way to learn cause and effect, for example, is by playing a turn-taking game; stop the activity for the moment, and wait for the child to indicate that the game should continue. A child may notice, “If I move my leg when Daddy stops swinging me, Daddy starts swinging me again!”; “If Mummy stops bouncing me, I move my arms up and down, Mummy starts bouncing me again!”.

Examples of using human contact instead of a toy include:
- Instead of pushing a button to cause a toy to pop up, push against father’s arm to make his arm pop up (in a specific and predictable pattern every time).
- Instead of touching a toy to cause it to move, touch mother’s hand to make it move in a particular way.

During these activities, be sure to acknowledge when a child’s behavior, such as turning away or diverting the eyes, communicates a need for a break, time for processing, or going to the toilet. These signals are often delicate, but it is important
to learn to recognize them and understand the needs they express. These types of behaviors can be misinterpreted as refusal or disinterest in a person or activity. However, just imagine the energy that is required by children who are deafblind, and who often have additional disabilities or complex medical conditions, to try to use what little vision or hearing they may have.

During activities, maintain conversations by using finger play and by singing songs with specific patterns. Always allow time for the child to initiate contact with you and to respond to your interactions. Some people may have a special song or rhyme that they sing every time they greet a child and this can become a type of “song signature”.

Allow the child to have access to your face, especially to your mouth. If a child’s hand or fingers make contact with your face, immediately respond by vocalizing, talking, or singing. “Chin-to-chin” is another technique that can be very effective. It involves talking or singing with your chin in contact with the child’s chin, allowing the child to feel the vibrations from your vocal chords and breathe flow.

In summary, don’t stop using toys – there is definitely a time and place for some. However, stop and think before offering a toy. Maybe there is another way. We don’t always have the luxury of one-on-one time to spend with children. When we do, the most valuable activities are those that involve personal interaction, turn-taking, imitation, conversation, and the enjoyment of being connected with another human being.
Part 4: Social, emotional and behavioral disorders

Introduction

Emotional and behavioral disorder (EBD) is a broad term used commonly in educational settings, to group a range of more specific difficulties experienced by children and adolescents. Both the general definitions and the concrete diagnosis of EBD may be controversial, as the observed behavior may depend on many factors. Behavioral disorders, also known as conduct disorders, are one of the most common forms of psychopathology among children and young adults, and are the most frequently cited reason for referral to mental health services. In Rwanda, these services are available. As a result, their presence severely constrains the ability of school systems to educate students effectively. The prevalence of behavioral problems among children and young adults is substantial.

Unit one: Characteristics of EBD

Behavioral disorders become apparent when the child displays a repetitive and persistent pattern of behavior that results in significant disruption of others in the class. Such disturbances may cause significant impairments in academic, social, and/or occupational functioning. Such a behavior pattern is consistent throughout the individual’s life.

Among the characteristics of a behavioral disorder among children and adolescents are:

- initiation of aggressive behavior and reacting aggressively towards others
- display of bullying, threatening, or intimidating behavior
- being physically abusive towards others
- deliberate destruction of others’ property
- showing little empathy and concern for the feelings, wishes, and well being of others
- showing callous behavior towards others and lack of feelings of guilt or remorse
- informing on companions and/or tending to blame others for their own misdeeds.

Children who have emotional and behavioral disturbances exhibit significant behavioral excesses or deficits. These terms refer to patterns of behavior that depart significantly from the expectations of others. In recent years, “behavioral disorders” has gained favor over “emotional disturbance” as a more accurate label, meaning cases of children that deviate from normal and acceptable behaviors.
Serious Emotional Disturbance (SED) refers to a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance: an inability to learn which cannot be explained by intellectual, sensory, or health factors. In other words, it is an inability to build or maintain satisfactory interpersonal relationships with peers and teachers. This is expressed by inappropriate types of behavior or feelings under normal circumstances, a general pervasive mood of unhappiness or depression, a tendency to develop physical symptoms or fears associated with personal or school problems.

Unit 2: Types of EBD

There is considerable agreement about general patterns or types of disordered behavior.

Achenbach suggests two discrete patterns that he calls:

1. “externalizers" (aggressive, disruptive, acting out)
2. “internalizers" (withdrawn, anxious, depressed).

Quay identifies the following dimensions:

- conduct disorders (aggression, disobedience, irritability)
- personality disorders (withdrawal, anxiety, physical complaints)
- immaturity (passivity, poor coping, preference for younger playmates)
- socialized delinquency (involvement in gang subcultures).

What are the educational implications?

Multidisciplinary educational teams (in Rwanda, such a team composes of parents, head teachers, teachers, an educationalist and a health worker) must design programs to meet the individual behavioral and academic needs of identified SED students. Most students can benefit from supportive treatments provided in regular programs. For others, at least temporary placements in special private classrooms (eg. an unoccupied room), schools, or institutional programs may be appropriate.

Special programs, like those offered in Rwandan specialized centres, usually attempt to provide a structured environment where students experience a high degree of success, such as:

Rules and routines are predictable and students are consistently rewarded for appropriate behavior.

Behavior management techniques, such as positive reinforcement, token economies, contracting, and time-out, which rely on direct measurement and monitoring of behavioral change, are commonly used in SED programs. The assessment and systematic teaching of social skills through modeling, discussion, and rehearsal are frequently used to help students increase control over their behavior and improve their relations with others.
Supportive therapies involving music, art, exercise, and relaxation techniques, as well as affective education, individual, and group counseling are sometimes employed to improve self-understanding, self-esteem, and self-control.

**How to handle children with EBD?**

Often EBD students may have other disabilities such as autism and attention deficit hyperactivity disorder. When handling students with EBD, consider the following advice:

*Routine:* Provide a structured routine with a visual time clock. Auditory sound cues may be helpful in addition to visual cues to help students manage their time efficiently.

*Changes in routine:* Convey any changes of routine to students as soon as available. The sooner students are aware of changes, the more time they have to adjust to the new routine.

*Classroom job chart/classroom order chart:* Classroom jobs offer an opportunity for students to show responsibility. In order to ensure success, make sure students have an opportunity to experience every job. One suggestion is having a chart with each student’s name and job. Every week rotate the jobs. The list can double as the order in which students line up or choose preferred activities. Students with EBD classification tend to be competitive and need specific procedures informing the order students line up and choose activities.

*Logical consequences:* Students must fix what they break. If a student pushes over a desk, he/she must pick it up. If a student runs when they shouldn’t, he/she must practice walking the correct way. If the student talks during the lesson, he/she must make up the work on his/her own time. Be consistent with consequences so students know what is expected of them.

*Target behaviors:* After assessing and taking data on students’ observable behavior, determine which behavior or behaviors to direct attention at. This exercise is done through an individual educational assessment teachers do normally do before they plan for every individual learner having special educational needs and/or with disability. Work with the student to develop a plan to replace undesirable behavior with a more suitable behavior. If the student throws desks and pencils when angry, have them work on communicating anger to an adult or trusted peer and how to be assertive without being aggressive.

*Small flexible grouping:* Students with EBD may have difficulty establishing relationships with peers. Abusive language and other behaviors may interfere with learning. Smaller groups decrease distractions and student-to-teacher ratio. Differentiation of instruction is more manageable with smaller groups.

*Audience:* During a serious behavior episode, the most effective strategy may be to remove the audience. The audience typically is other peers but may be other adults. The audience can be removed by moving the student if he or she is willing. However,
moving the audience may be necessary in some cases. Develop a procedure with your class which will function as an “everybody out” drill. Behaviors amplified with an audience may be reduced or completely stopped when an audience is removed.

*Calm spot:* Have a designated area of the classroom where students go to calm down. This spot can be used proactively to prevent behaviors. Alternatively, the spot may be used after a behavior occurs to give the student a chance to refocus.

*Choices:* Students may frustrate easily when doing work. Giving students an option of when to complete the work is a powerful tool. For example, a teacher may say, “You need to get this done today. Would you rather do it now or during your free time?”

**Unit 3: Teaching children with EBD**

- Bring to the student’s attention any role models who have a similar disorder to their own. Point out that these individuals got ahead by a combination of effort and by asking for help when needed.
- Ask previous teachers about interactive techniques that have been effective with the student in the past.
- Expose students with behavioral disorders to other students who demonstrate appropriate behaviors.
- Direct instruction or target behavior is often required to help students master them.
- Have pre-established consequences for misbehavior. Administer consequences immediately, and then monitor proper behavior frequently.
- Determine whether the student is on medication, what the schedule is, and what the medication effects may be on his or her in class demeanour with and without medication. This is applicable since every Rwandan citizen has health insurance and parents are mobilized to send their children to health centres.
- Use time-out sessions to cool off disruptive behavior and as a break if the student needs one for a disability-related reason.
- In group activities, acknowledge the contributions of the student with a behavioral disorder.
- Devise a contingency plan with the student in which inappropriate forms of response are replaced by appropriate ones.
- Treat the student with the behavioral disorder as an individual who is deserving of respect and consideration.
- When appropriate, seek input from the student about their strengths, weaknesses and goals.
- Enforce classroom rules consistently.
- Make sure the discipline fits the “crime”, without harshness.
- Provide encouragement. Reward more than you punish, in order to build self-esteem. Praise immediately all good behavior and performance.
- Change rewards if they are not effective for motivating behavioral change.
- Develop a schedule for applying positive reinforcement in all educational environments.
- Encourage others to be friendly with students who have emotional disorders.
- Monitor the student’s self-esteem. Assist in modification, as needed.
- Self-esteem and interpersonal skills are especially essential for all students with emotional disorders.
- Do not expect students with behavioral disorders to have immediate success; work for improvement on an overall basis.
- As a teacher, you should be patient, sensitive, a good listener, fair and consistent in your treatment of students with behavioral disorders.
- Present a high degree of possessiveness in the classroom environment.

**Teacher's presentation**

- By using examples, encourage students to learn science so they can emulate adult behaviors.
- Check on the student’s basic capacity to communicate and adjust your communications efforts accordingly.
- Use a wide variety of instructional equipment which can be displayed for the students to look at and handle.
- When an interest in a particular piece has been kindled, the teacher can talk to the student about it and show him or her how to use it.
- Instructions should be simple and very structured.
- Group participation in activities is highly desirable because it makes social contacts possible.
- Monitor the student carefully to ensure that students without disabilities do not dominate the activity or detract in any way from the successful performance of the student with the behavioral disorder.
- Put an individual with a behavioral disorder in charge of an activity; this can often reduce aggressiveness.
- Special efforts should be made to encourage and easily facilitate students with behavioral disorders to interact.
- The environment must be structured, but sensitive to the needs of these youth with behavioral disorders.
- Direct instruction or target behaviors is often required to help students master them.
- Consultation with other specialists, including teacher having skills in special education, psychologists, and others may prove helpful in devising effective strategies.
- Keep an organized classroom learning environment.
- Devise a structured behavioral management program.
- As an educator you serve as a model for the students who are behaviorally disturbed. Your actions therefore, must be consistent, mature, and controlled. Behavioral outbursts and/or angry shouting at students inhibit rather than enhance a classroom.
- Let your students know the expectations you have, the objectives that have been established for the activity, and the help you will give them in achieving objectives.
- You should refer the students to visual aids and reading materials that may be used to learn more about the techniques of skill performance.
- Remain calm, explain which rule has been broken, and avoid debating or arguing with the student with a behavioral disorder.
Group interaction and discussion

- Call for responses and participation that match with the student’s socialization skills.
- As the student’s comfort level rises and if there is a safe topic,, encourage the student to be a group spokesperson.
- Gradually increase the challenges in the student’s participation in group exercises while providing increased positive reinforcement.
- Help the student to feel as though he or she has something worthwhile to contribute to the discussion.
- Some students may experience considerable strain in social adjustment in a group context. It may be necessary to work gradually toward group activities. One can devise a strategy of progressing from spectatorship to one-to-one instruction and eventually to small group discussion.

Reading

It is necessary to target specific prosocial behaviors for appropriate instruction and assessment to occur such as:

- taking turns, working with a partner, following directions
- reading in group or with others
- increasing positive relationships by means of awards when they read appropriately
- demonstrating appropriate reading

It is advised to use instructional strategies involving self-control, self-reinforcement, self-monitoring, self-management, problem-solving, cognitive behavior modification, and metacognitive skills should be focused on teaching students reading skills.

Testing

When giving an evaluation, remember to:

- Be sensitive to the student’s reactions to the various aspects of assessment.
- Use several examples of work (quizzes, assignments, projects) that demonstrate knowledge of the subject matter or the unit of study.
- Make special arrangements for the student with an emotional disorder according to what their special needs are and ensure that they do not compromise the integrity of the testing situation.
- Stay on top of student progress through informal assessment; don’t wait until it’s too late to discover that there is a problem.
- Provide private room/smaller group setting/alternative test site (with proctor present); alternatively screens to block out distractions.
**Activity 1:**
Differentiate types of EBD according to Quay and Achenbach’s points of view.

**Activity 2:**
As a teacher, describe briefly how you could handle children with EBD.
References


