Curriculum Web

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**Appendix**

Considering Technology in the Inclusive Classroom
(1) **What’s the difference between the diagnosis of Autism and that of Asperger’s Disorder?**

There are about five similar disorders, all of which involves problems with communication skills, social interaction, repetitive, and stereotyped patterns of behavior are autism. Asperger’s syndrome, Rett syndrome, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified.

Autism is characterized by severe deficits in communications, social interaction, and cognitive functioning, and often involves repetitive, stereotyped movements, resistance to change, and unusual sensory perception.

In Asperger’s syndrome have higher cognitive and language skills than those with classic autism, but have problems with social interactions. Asperger’s syndrome is a milder form of autism without significant impairment in language and cognition which is characterized by primary problem in social interaction.

Asperger’s Syndrome does not have delays in the area of communication and language. In fact, to be diagnosed with Asperger’s, a child must have normal language development as well as normal intelligence. The DSM-IV criteria for AS specifies that the individual must have "severe and sustained impairment in social interaction, and the development of restricted, repetitive patterns of behavior, interests and activities that must cause clinically significant impairment in social, occupational or other important areas of functioning."

In Autism show evidence of resistance to environmental change or change in daily routines, and unusual responses to sensory experience which is usually evident before age 3 years. Persons with autism may appear to have an intellectual disability, a sensory integration disorder, or problems with hearing or vision. Autism is diagnosed as neurological and hereditary conditions where the area of the brain is implicated because of the excessive brain growth in the first two years of life.

There are other conditions that can co-occur with autism because about 30 percent of children have to deafness/hard of hearing and blindness/visual impairment related condition identified as having autism. Many children with autism also suffer immune system deficiencies. Many children with autism have unusual sensory integration disorder such as sensitivities to sounds, sights, touch, taste and smells. About 30 percent of children with autism have moderate to severe loss of muscle tone, which can limit their gross and fine motor skills. About 30 percent of children with autism have moderate to severe pica. Pica refers to eating non-food items such as paint, sand, dirt, paper, etc. Pica
can be dangerous as ingesting these inedible substances can cause choking, digestive problems, parasitic infections and illness. Many individuals with autism have sleep problems. Night waking may be due to gastrointestinal issues, food/environmental allergies or intolerances, seizures or the effects of medications. Whereas, Asperger’s syndrome may have co-morbidity with emotional disability, gifted and talented, Tourette (tic) syndrome, OCD and other neuropsychological conditions.

Recent medical literature cites that 70-80 percent of autistic children have gastrointestinal symptoms. Diarrhea is most common, abdominal pain is cited next most frequently, and constipation is reported slightly less. It is also reported that about 11-39% of autistic individuals also develop seizures, some in early childhood and others as they go through puberty as changes in hormone levels may trigger seizures. Suspected seizures should be confirmed by electroencephalogram (EEG) and treated with anticonvulsant medications.

There is no universally used diagnostic test for ASD, however for autism the clinician uses criteria that focus on communications skills, social interactions, and repetitive and stereotyped pattern of behavior. Asperger’s syndrome, the clinician looks for normal or close to normal communications abilities but problems in social interaction and repetitive and stereotyped pattern of behavior, but it manifest lesser extent than in classic autism.

Children and adults with Asperger’s Syndrome have an intellectual capacity within the normal range, but have a distinct profile of abilities that has been apparent since early childhood. impairment in social interaction, Failure to develop friendships that are appropriate to the child’s developmental level, Impaired use of non-verbal behavior such as eye gaze, facial expression and body language to regulate a social interaction, Lack of social and emotional reciprocity and empathy and Impaired ability to identify social cues and conventions. Children and adults with Asperger’s Syndrome have impairment in subtle communication skills and might have fluent speech but difficulties with conversation skills (pragmatics).
(2) What are the best strategies parents and teachers can use to help students with (a) Autism (b) Asperger’s Disorder

**Autism**

**Best Strategies for Parents with Autism Child or Youth**

- Begin and manage in an intensive therapy treatment program
- Engaged in meaningful activities, you will be more able to focus on moving forward.
- Educate yourself, advocate for your child needs
- Support groups can be great sources for information about what services are available in your area
- “writing journals that describes traumatic events and journaling a helpful tool for keeping track of their autism child's progress,
- Autism children should be encourage to participate in all family activities

**Best Strategies for teachers with Autism Child or Youth**

- Functional, spontaneous communications
- Social skills development that are age-appropriate
- Play skills especially with peers
- Cognitive skills that are useful and applied in everyday
- Appropriate behavior to replace problem behavior
- Functional academic skills, when appropriate to the need of the child.

**Educational programming for Autism**

- Teacher should create a predictable environment built upon consistent routines
- Teacher students how to read and respond to social cues
- Encourage other students to teamwork with autism students
- Create rules for engaging in discussion or activities
• **Direct instruction**: the use of argumentative or alternative communication (ACC)
• Picture Exchange Communication System (PECS) these tools will enhance social interaction of students with Autism.
• **Behavior management**: The use behavior tools to manage certain inappropriate behavior functional behavioral assessment and positive behavior support
• **Instructional in natural setting** with emphasis on language and social skills

**Asperger’s Disorder**

**Best Strategies for Parents with Asperger’s Child or Youth**

• Difficulties with social cues will require an explanation rules
• consequences of his behavior clearly and logically explained
• Celebrate your Asperger’s youngster's humor, creativity, and passion.
• Make an appointment with your youngster to discuss the issue.
• to model negotiation, not inflexibility
• Set a reward for the correct behavior you would rather replace it with. Rewards should be immediate, frequent, powerful, clearly defined, and consistent.
• disability outlook” will help because it eliminates blame; sets reasonable expectations

**Best Strategies for Teachers with Asperger’s Child or Youth**

• Train techniques in social interpreting
• Instruction in social skills and Academic
• Structured behavior support
• Skills acquisition and Communications
• Teaching social cues using comic strips and cartooning can be a positive way to assist students in understanding complex social interaction
• Records of behavior of an incident
• Repeated planned activities and group instruction to meet individualized goals

Sources: [www.Autism-society.org](http://www.Autism-society.org)  
[www.asperger.org](http://www.asperger.org)
(3) **What types of modifications can be made in a classroom for children with hearing loss?**

**Method of instructions**
- Auditory-verbal approach emphasis on using the remaining hearing and utilize amplification for speech teaching i.e. Auditory-Oral approach
- speech reading involves teaching children who are hearing impaired to use visual information to understand what is being said to them as well as: visual cues or information Designing classroom that maximizes opportunities for visual and/or auditory learning.
- Providing activities to promote literacy in English and American sign language: i.e. Total communication-: finger spelling and signing English system
- Oralism-manualism: teaching hearing impaired to speak or teach them to use sign language.
- Bicultural-bilingual approach: teach hearing impaired American sign language as first language and English as a second language to promote deaf culture.
- Modifying incidental language experience to fit visual and other sensory needs

**Assistive Technology**
- Amplification devices frequency modulated FM or hearing aid and Amplification technology such as hearing aids and cochlear implants
- Captioned programming
- Telecommunication devices for the deaf (TDD)
- Speech digitizer and synthesizer
- Hearing Aids
- Television, video, and movie captioning
- Telephone Adaptation
- Computer-Assisted instructions
- Universal design learning: multiple ways of representing content into electronic text

**Classroom interactions and instructions**
- Modifying the classroom
• Place students who use amplification devices away from distracting background, noises, such as doors and windows
• Provide ample lighting on instructional visual aids
• Allow the students with hearing impaired to see the teacher and classmates’ faces and ability to move around
• Use finger spelling
• Use visual support (bulletin board, computers, television, pictures, graphs, graphic organizer, film
• Face student when speaking, avoid talking on the board while talking
• Repeat questions and avoid note taking and use nonverbal cues to emphasize verbal directions
• Provide access to students dominant mode of communication (manual, cued, and oral)
• Effective rules for communication practice—signing before speaking
• Moderate the volume, rate, and complexity of speech.

Sources:
www.agbell.org
www.cici.org
(4) How do cochlear implants work?

This procedure involves surgically implanting electronic elements under the skin behind the ear and in the inner ear. A small microphone worn behind the ear picks up sound and sends it to a small computerized speech processor worn by the person. The speech processor sends coded signal to an external coil worn behind the ear, which sends them through the skin to the implanted internal coil. The internal coil sends signal to electrodes implanted in the inner ear, and these signals are sent on to the auditory nerve. A cochlear implant works by using special electronic technologies to take the place of non-working parts in the inner ear. It's designed to mimic natural hearing. The transmitting coil of the external device is secured over the receiver/stimulator of the internal device through magnetic attraction.

**Sound processor:** Sound is picked up by a tiny microphone sensitive to the direction from which sounds come. This lets it pick up more sounds from in front of the user and fewer from behind them. External sound processor captures sound and converts it into digital signals.

**Digital signals:** The signals are sent across the skin to the internal implant. This is done with technology similar to the way a radio station broadcasts its signal, but on a much smaller scale.

**Electrode array:** Internal implant converts signals into electrical energy, sending it to an electrode array inside the cochlea.

**Hearing nerve:** Electrodes stimulate the hearing nerve, bypassing damaged hair cells, and the brain perceives signals as sound.

Sources:

[www.agbell.org](http://www.agbell.org)
[www.cici.org](http://www.cici.org)
Name some areas that can be affected by a learning disability?

A learning disability is defined as "a childhood disorder characterized by difficulty with certain skills such as reading or writing in individuals with normal intelligence." It's also defined as a "significant gap between a person's intelligence and the skills the person has achieved at each age."

The primary indicator of a learning disability is a considerable difference between a child's ability (based on age and intelligence) and his actual level of development. A grade school child is considered to have a learning disability if there is at least a two-year gap between where a child is and where he should be at grade level or instructional level. Learning disabilities typically show up as a developmental issue in either verbal/writing skills or mathematical skills, while learning in other areas progress normally.

There are five different areas that can be affected by learning disabilities:

1. **Spoken language**: delays, disorders, and deviations in listening and speaking.
2. **Written language**: difficulties with reading, writing and spelling.
3. **Arithmetic**: difficulty in performing arithmetic operations or in understanding basic concepts.
4. **Reasoning**: difficulty in organizing and integrating thoughts.
5. **Memory**: difficulty in remembering information and instructions.\(^3\)

Some symptoms that may indicate a learning disability include:

- Poor short-term or long-term memory
- Poor organizational skills
- Difficulty discerning size, shape, and/or color
- Difficulty understanding concepts of time
- Being easily confused by instructions
- Disorganized thinking
- Difficulty with abstract reasoning and/or problem solving
- Obsessive focus on one idea or topic
Auditory processing disorder (APD), also known as central auditory processing disorder (CAPD), is a complex problem affecting about 5% of school-aged children. There are many individuals who have no trouble detecting the presence of sound, but who have other types of auditory difficulties (e.g., difficulties understanding conversations in noisy environments, problems following complex directions, difficulty learning new vocabulary words that can affect their ability to develop normal language skills, succeed academically, or communicate effectively.

There are several different ways to help children overcome their APD. The exact procedures or approaches used will depend upon a number of factors, including the exact nature of the APD, the age of the child, the co-existence of other disabilities and/or problems, and the availability of resources. Some of the strategies utilized effectively are; In general, the approaches to remediation or management fall into three main categories:

- Enhancing the individual's auditory perceptual skills,
- Enhancing the individual's language and cognitive resources, and
- Improving the quality of the auditory signal.
- Changing the learning or communication environment,
- Recruiting higher-order skills to help compensate for the disorder and
- Remediation of the auditory deficit itself.

The following strategies could be employed in the classroom as well depending on the resources.

1. The use of electronic devices that allow a person to focus attention on a speaker and reduce the interference of background noise. They are often used in classrooms, where the teacher wears a microphone to transmit sound and the child wears a headset to receive the sound. Children who wear hearing aids can use them in addition to the auditory trainer. The primary purpose of environmental modifications is to improve access to auditory presented information.

2. The environmental modifications such as classroom acoustics, placement, and seating may help. An audiologist may suggest ways to improve the listening environment, and he or she will be able to monitor any changes in hearing status.

3. Extensive exercises to improve language-building skills can increase the ability to learn new words and increase a child’s language base.
4. An auditory memory enhancement, a procedure that reduces detailed information to a more basic representation, may help. Also, informal auditory training techniques can be used by teachers and therapists to address specific difficulties.

5. Auditory integration training may be promoted by practitioners as a way to retrain the auditory system and decrease hearing distortion. However, current research has not proven the benefits of this treatment.

Sources
www.idinfo.com
www.ncid.org
What are the most common types of anxiety disorders in children?

All children experience some anxiety; this is normal and expected. For example, when left alone at preschool for the first time, many children will show distress; a young child with his or her own room may develop a fear of the dark. Such anxiety becomes a problem when it interrupts a child’s normal activities, like attending school and making friends or sleeping. The persistent and intense anxiety that disrupts among children can manifest into serious anxiety. There are several types of anxiety disorders that are most common among children.

Generalized Anxiety Disorder — Children with generalized anxiety disorder (GAD) have repeated fears and worries that they find difficult to control. They worry about almost everything—school, sports, being on time, even natural disasters. They may be restless, irritable, tense, or easily tired, and they may have trouble concentrating or sleeping. Children with GAD are usually eager to please others and may be “perfectionists” who are dissatisfied with their own less-than-perfect performance.

Separation Anxiety Disorder — Children with separation anxiety disorder have intense anxiety about being away from home or caregivers that affects their ability to function socially and in school. These children have a great need to stay at home or be close to their parents. Children with this disorder may worry a lot about their parents when they are apart from them. When they are together, the child may cling to parents, refuse to go to school, or be afraid to sleep alone. Repeated nightmares about separation and physical symptoms such as stomachaches and headaches are also common in children with separation anxiety disorder.

Social Phobia — Social phobia usually begins in the mid-teens and typically does not affect young children. Young people with this disorder have a constant fear of social or performance situations such as speaking in class or eating in public. This fear is often accompanied by physical symptoms such as sweating, blushing, heart palpitations, shortness of breath, or muscle tenseness. Young people with this disorder typically respond to these feelings by avoiding the feared situation. For example, they may stay home from school or avoid parties. Young people with social phobia are often overly sensitive to criticism, have trouble being assertive, and suffer from low self-esteem. Social phobia can be limited to specific situations, so the adolescent may fear dating and recreational events but be confident in academic and work situations.

Obsessive-compulsive Disorder — Obsessive-compulsive disorder (OCD) typically begins in early childhood or adolescence. Children with OCD have frequent and uncontrollable thoughts (called “obsessions”) and may perform routines or rituals (called “compulsions”) in an attempt to eliminate the thoughts. Those with the disorder often repeat behaviors to avoid some imagined consequence. For example, a compulsion common to people with OCD is excessive hand washing due to a fear of
germs. Other common compulsions include counting, repeating words silently, and rechecking completed
tasks. In the case of OCD, these obsessions and compulsions take up so much time that they interfere
with daily living and cause a young person a great deal of anxiety.

**Post-traumatic Stress Disorder** — Children who experience a physical or emotional trauma such as
witnessing a shooting or disaster, surviving physical or sexual abuse, or being in a car accident may
develop post-traumatic stress disorder (PTSD). Children are more easily traumatized than adults. An
event that may not be traumatic to an adult—such as a bumpy plane ride—might be traumatic to a
child. A child may “re-experience” the trauma through nightmares, constant thoughts about what
happened, or reenacting the event while playing. A child with PTSD will experience symptoms of general
anxiety, including irritability or trouble sleeping and eating. Children may exhibit other symptoms such
as being easily startled.

**Sources**

[www.nmha.org/infoctr/](http://www.nmha.org/infoctr/)
(8) Name some multimodal treatments for AD/HD

Multimodal treatment is the most effective form of treatment for children and adolescents with AD/HD. This treatment approach includes multiple elements which work best together and support each other. These various interventions or "modes" of treatment reinforce each other and produce the best outcomes for children and adolescents with AD/HD. The elements of the multimodal treatment approach include: parent and child education about diagnosis and treatment, specific behavior management techniques, stimulant medication, and appropriate educational program and supports.

In the Multimodal Treatment of ADHD the effects of medication management (Medication and behavior Management) and behavior modification therapy (Behavior) and their combination (Comb) and usual community care (CC) in the treatment of attention-deficit/hyperactivity disorder (ADHD) is very effective.

1) Medication management
There are basically two classes of stimulants: methylphenidate and amphetamine products. Stimulant preparations can be quick-acting (within 30 minutes) and short lasting (four to six hours) or longer lasting (eight to 12 hours). Preparations, such as Vyvanse, Daytrana, Concerta, Adderall XR, Focalin, Methylin, Metadate and Ritalin LA, offer once-a-day dosing lasting from 8 to 12 hours. Atomoxetine, brand name, Strattera, is a non-stimulant drug that was approved in November, 2002 and became available in US pharmacies in early 2003 for children and adults with ADHD. It is a selective norepinephrine reuptake inhibitor. While the stimulants primarily affect the dopaminergic system, atomoxetine has its primary effect on the noradrenergic system. It has been shown to improve core symptoms of ADHD, namely, inattention, impulsivity, and hyperactivity. It has some weak antidepressant properties as well and may help improve and regulate mood. While stimulants start working within a half hour to an hour after ingestion, atomoxetine has a more gradual onset and the maximal effect may not be seen for three weeks. Certain anti-hypertensive medications known as adrenergic agonists (Clonidine and Tenex) are used in combination with other medications to help very hyperactive and impulsive children.

2) Behavioral Treatment of five categories of behavioral treatment:
   - cognitive-behavioral interventions
   - clinical behavior therapy
   - direct contingency management
   - intensive, packaged behavioral treatments
   - combined behavioral and pharmacological treatments
In 2001, the American Academy of Pediatrics (AAP) published clinical practice guidelines for the treatment of school-aged children with ADHD. The AAP recommended the following:

1. Primary care clinicians should establish a treatment program that recognizes ADHD as a chronic condition;
2. Appropriate target outcomes designed in collaboration with the clinician, parents, child and school personnel should guide management;
3. Stimulant medication and/or behavior therapy as appropriate should be used in the treatment;
4. If a child has not met the targeted outcomes, clinicians should evaluate the original diagnosis, use all appropriate treatments and consider co-existing conditions;
5. Periodic, systematic follow-up for the child should be done with monitoring directed to target outcomes and adverse effects. Information for monitoring should be gathered from parents, teachers and the child.

Other treatments, including individual counseling, play therapy, dietary interventions, treatment for inner ear problems, neurofeedback/biofeedback, perceptual-motor training, sensory integration training, chiropractic manipulation, pet therapy and others have no proven efficacy for ADHD.

Academic performance of children with ADHD can be improved by using known treatments in the classroom and by teachers making appropriate accommodations in school to assist the student. Retrieved from http://www.myadhd.com/treatmentsforadhd.html

**Combined Pharmacological and Behavioral Interventions**

This form of treatment focuses on the combined use of medication and behavioral treatment. This combination has been shown to be quite effective in treating children with ADHD and has several advantages over medication alone or behavioral treatment alone. With the addition of medication, the behavioral component of treatment may be able to be scaled down, thereby reducing the amount of time parents and teachers need to spend on shaping behavior. The dose of medication can be reduced for children using a combined approach. Parents knowledgeable about the use of behavioral treatments can apply such treatments during times when the child is not taking medication (i.e., in the evenings for those on stimulant medication).

**Sources:**

www.chadd.org/
http://nichcy.org/pubs/
(9) What are the educational/employment implications for a child with Down syndrome?

Educational implication

When a child with Down syndrome reaches school age (after the 3rd birthday), the public school system becomes responsible for educating the child and for addressing the child’s unique needs related to his or her disability. Parents and school personnel will work together to develop what is known as an Individualized Education Program (IEP) for the child. The IEP is similar to an IFSP in that it describes the child’s unique needs and the services that will be provided to meet those needs. The IEP will include annual goals for learning and much more. The teacher should be into consideration effective teaching practices that would benefit children with Down syndrome and the degree of intellectual disability involved, the child’s talents and interests, and the supports and services he or she needs, as specified in the IEP.

Generally speaking, teachers will find it more effective to emphasize concrete concepts with a student who has Down syndrome, instead of abstract ideas. Teaching skills in a step-by-step fashion with frequent reinforcement and consistent feedback has proven successful. Today, the majority of children with Down syndrome are educated in the regular classroom, alongside their peers without disabilities. This is in keeping with the inclusion movement of the last decade and the requirements of IDEA, which states that each school system must ensure that:

Special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only if the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily

Teaching implication for Students with Down Syndrome

The teacher responsibility is to identify techniques and specific strategies to support the student’s learning. The teacher needs to work with the student’s parents and other school personnel to develop and implement a special educational plan (IEP) that addresses the individual needs of the student. Share information on a regular basis with parents about how things are going for the student at home and in school.

1. They can help you identify methods that are effective for teaching a student with disabilities, ways to adapt the curriculum, and how to address the student’s IEP goals in the classroom.
2. Teacher need to demonstrate what you want to see happen instead of giving only verbal instructions. When you share concrete information verbally, also show a photograph. Give the student practical materials and experiences and the opportunity to touch and examine objects.
3. Divide new tasks and large tasks into smaller steps. Demonstrate the steps. Have the student do the steps, one by one. Offer help when necessary.
4. Give the student immediate, concrete feedback.
5. When planning a student's instructional program, be guided by the student's individual ability and needs, and not the label of Down syndrome.
6. If the student is highly distractible, seat the student away from windows and doors to minimize distractions in the environment.
7. Small group instruction may be more beneficial to the student than whole class instruction. Try to also set aside some time for one-on-one instruction.
8. Model the task and give the student many opportunities to perform it. Break down tasks into smaller sequenced steps.
9. Teacher will need to used effective questioning techniques by asking the student to repeat or rephrase instructions and asking the student specific step-by-step questions to make sure the student has understood the instructions given.
10. Set aside time for frequent review and practice of tasks and Allow the student adequate response time.
11. Provide consistent positive reinforcement immediately after the student produces a correct response.
12. Give clear signals about the end of one activity and the beginning of the next. Use picture cues or audio cues with young children. For example, use picture symbols representing activities or sing a certain song before a specific activity.
13. Present only a few stimuli or objects at a time. For example, if you are using worksheets, create worksheets that do not have too many pictures or sentences with complicated wording. Highlight or print key words in bold.
14. Use concrete objects/manipulative along with verbal explanations. For example, while teaching counting use manipulative that are alike in shape, size and color, so that the student concentrates on counting, rather than being distracted by shapes, etc.
15. Be flexible with attaining educational goals. For example, if the student has difficulty writing with a pencil, teach the student to write using a computer.

There are many opportunities for individuals with cognitive disabilities after graduation, most frequently considered are: post-secondary education, and employment. Today, there are more opportunities than ever
before for individuals with Down syndrome to pursue goals in these areas. Successful transitioning will not only depend on a good understanding of the individual's personal strengths and interests, but also on knowledge of what options and services are available in the community.

**Postsecondary education**

Individuals with Down syndrome have the opportunity to participate in a variety of postsecondary education programs, such as:

- Academic programs or courses at a community college or other college or university;
- Vocational or training programs, such as apprenticeships and trade schools; or
- Innovative programs that combine these two types of education.

Programs and schools vary widely in terms of what they offer with respect to academics, independent living skills training, residential options, and the type of diploma or certificate earned. And even though IDEA requires that all schools make proper accommodations for their students with disabilities, it is very important to find a school whose staff clearly respects the student's learning style and is willing to go the extra mile to meet his or her needs. As many of these post-secondary education programs have eligibility or entrance requirements and are not necessarily located in your community, it is important to start researching early. Knowledge of existing programs and entrance requirements can help identify specific goals to include in the transition plan. For example, students can plan to take certain courses in high school as preparation for particular programs. Or, they might secure part-time jobs or volunteer work in a specific field of interest. Deciding which program to enroll in is just like researching any college or program. It is important to find a good fit between the individual and the school.

**Employment implication**

In general, there are three types of employment options available to individuals with Down syndrome: competitive, supported and sheltered. In competitive employment, the individual secures employment in the community — for example, by responding to ads or job postings or proactively approaching businesses — and works independently without any support services. More common is supported employment, in which the individual works in an integrated setting and receives support services from a job coach. The job coach accompanies the individual to the workplace to enable him or her to learn the necessary job skills and to prepare to work independently. Usually, the job coach works with the individual full-time at first, and moves toward the goal of providing only periodic support such as visiting the job site to assist in training the individual for new assignments.

In sheltered employment, individuals work in self-contained settings with others who have disabilities without the integration of non-disabled workers. Sheltered employment is often obtained through
agencies, and wages for this type of work are typically lower than for other types of jobs. Sheltered employment usually involves manual labor tasks such as assembling goods. In addition to these types of employment, there are also many innovative programs that focus on business ownership and entrepreneurship for individuals with disabilities. These businesses may include artistic or creative ventures that allow the individual to focus on a specific talent or ability, such as photography or public speaking.

Regardless of the type of employment that is pursued, the challenge will often be locating a job and coordinating appropriate support services. There are laws and government agencies that aid individuals with disabilities in defining their employment goals, locating jobs, and obtaining the services they need to perform those jobs successfully.

Sources

http://www.ndss.org
http://nichcy.org/pubs/fact she/fs4txt.htm
www.ndss.org
www.ndsccenter.org
www.downsyndrome.com
http://nichcy.org/disability/specific/downsyndrome
(10) Name some sensitivity that needs to be exhibited toward children with Tourette syndrome.

Tourette's syndrome (sometimes called Tourette's disorder) is a childhood-onset condition characterized by motor and vocal tics that are chronic (duration of >1 year). The standard diagnostic criteria for Tourette's syndrome are listed in Table 1.¹ Motor tics include simple tics such as twitching, eye blinking, facial grimacing, or head jerking; slow twisting movements (dystonic tics); isometric

Children with Tourette syndrome (tic disorders) are sensitive to stress, attempting to maintain a low-stress environment can help minimize the number or severity of tics (reducing the number of social school gatherings, which can be anxiety-provoking, for example). This approach cannot prevent tics altogether, and must be undertaken with an awareness that it is neither healthful nor advisable to attempt to eliminate all stressful events in life.

Since the child wants to be like other children, their environment must be one of understanding. Everyone that comes in contact with the child should be informed of the child's condition. Teachers, family and friends need to know that the child has no control over their condition. No matter how disturbing it becomes the child should never be forced to try to stop. It is wise to remember no matter how frustrated anyone becomes at the child that the child is in an uncontrollable world and feels helpless in their situation.

SOURCES

www.tsa-usa.org/
www.tourettessyndrome.net/
(11) Why is self-determination an important outcome for people with mental retardation?

Intellectual disability is a below-average cognitive ability with three (3) characteristics: Intelligent quotient (or I.Q.) is between 70-75 or below, significant limitations in adaptive behaviors (the ability to adapt and carry on everyday life activities such as self-care, socializing, communicating, etc.) and the onset of the disability occurs before age 18. Intelligence refers to general mental capability and involves the ability to reason, plan, solve problems, think abstractly, comprehend complex ideas, learn quickly, and learn from experience.

The Self-Determination for People with intellectual Disabilities giving those persons and their families more choice in determining the services they receive. Self-determination refers to the right of individuals to have full power over their own lives. Self-determination is achieved when individuals are full participants in family and community life, and are empowered to organize for social rights and justice for themselves and their peers. Self Determination is based on the principles of choice, control, quality, stability, safety, individuality, freedom, relationships, success, mentoring, accountability, collaboration, and opportunities to contribute to the community.

Self Determination involves deciding how to live your life, deciding what supports you need, and deciding how to spend your approved funding. It encompasses concepts of freedom in the political, economic, cultural, and social context in which people live, vote, work, participate in community activities, raise families, socialize, and otherwise relate to each other.

- Freedom—the right to make choices.
- Authority—the right to decide how to spend money
- Support—the right to choose the people you want to help you
- Responsibility—the need to do things the right way
- Confirmation—the need for people to listen to you because this is your life

http://www.thearc.org

(12) What are some sports programs available to people with cerebral palsy?

People with cerebral palsy are at risk of having muscle tightness that limits the motion of their joints. This lack of flexibility can lead to pain, plus a loss of balance and mobility. Therapy and exercises for cerebral palsy patients should be designed to increase mobility and strength and therefore eliminate the pain and problems.

**Stretching**

Stretching exercises can help lengthen, loosen and strengthen tight or weak muscles that are caused by cerebral palsy. It is extremely important to perform daily stretches, to keep muscles loose and limber.
United Cerebral Palsy recommends focusing stretching work on muscles that are causing problems with mobility in daily activities. Stretch the muscles slowly to the point of tension but not pain. Hold each stretch for 10 to 60 seconds and repeat two to three times each.

**Yoga**

Yoga movements ease stress and improve mobility, flexibility and muscle tone. Yoga moves require an individual to sustain longer stretching periods and work muscles differently from standard stretching. Yoga forces the entire body to work via strength and flexibility to get itself into difficult poses and stretched positions. In addition, yoga is slow moving, which lessens any problems cerebral palsy patients could have with balance and coordination.

**Aquatic Exercise**

Aquatic-based rehabilitation and therapy for cerebral palsy can be effective. The water not only provides resistance, but it can also assist cerebral palsy patients to fully extend their muscles when they are unable to do so outside of the water. In addition, exercising in the water will not aggravate any joint or muscle pain, as water allows you to exercise without putting stress on the joints or muscles. Aquatic exercise programs can range from light water walking and hand rises to full strength training with weights underwater.

**Strength Training**

Lifting weights or strength training can help improve flexibility. Strength training should focus on full body compound exercises that work muscles through an entire range of motion. Resistance exercises that work joints through a full range of motion will increase flexibility. Training should focus on exercises like squats, dead lifts, pull-ups, push-ups and press exercises that work a variety of muscles to support your weight. These moves not only force you to get stronger, but you also improve your balance and flexibility as you support your weight during the lifts. [http://www.ucpa.org](http://www.ucpa.org)
Part 2  Curriculum Web

Part II: Choose a topic and design your own curriculum web. Limit to 5 questions.

<table>
<thead>
<tr>
<th>Learning disabilities</th>
<th>Curriculum Web</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is the main cause of learning disabilities?</td>
<td><a href="http://www.medterms.com">http://www.medterms.com</a></td>
</tr>
<tr>
<td>2. Why do some students have deficit in one area of learning and will have strength in another area?</td>
<td><a href="http://healthlink.mcw.edu">http://healthlink.mcw.edu</a></td>
</tr>
<tr>
<td>3. What do brain research tell us about learning disabilities</td>
<td><a href="http://www.childdevelopmentinfo.com">http://www.childdevelopmentinfo.com</a></td>
</tr>
<tr>
<td>4. What are some of the current research being conducted to help students with learning disabilities learn at school?</td>
<td><a href="http://www.ldonline.org/">http://www.ldonline.org/</a></td>
</tr>
<tr>
<td>5. What strategies are some of the useful in strategies to teach learning disabilities student at home and at school</td>
<td><a href="http://www.ncld.org/">http://www.ncld.org/</a></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.ldanatl.org/">http://www.ldanatl.org/</a></td>
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<tr>
<td></td>
<td><a href="http://www.ldworldwide.org/">http://www.ldworldwide.org/</a></td>
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</tbody>
</table>
Appendix Considering *Technology in the Inclusive Classroom*:

Students can gain academic information and research through both commercial and home-made products to achieve greater independence in schools and the community. Teachers can use technology to motivate and instruct students while increasing their own classroom productivity. Teachers in inclusive classrooms can use technology to enhance the curriculum, guide and monitor student usage for effective instruction. The Curriculum Web Search is one strategy teachers may use to have students research information on a given topic. Answer these questions by using the sites below.

**Curriculum Web Search**

<table>
<thead>
<tr>
<th><strong>Focus Questions</strong></th>
<th><strong>Web Sites</strong></th>
<th><strong>Answers</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What’s the difference between the diagnosis of Autism and that of Asperger’s Disorder?</td>
<td><a href="http://www.Autism-society.org">www.Autism-society.org</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.asperger.org">www.asperger.org</a></td>
<td></td>
</tr>
</tbody>
</table>
| 2. What are the best strategies parents and teachers can use to help students with
  a. Autism
  b. Asperger’s Disorder                                                          |                                       |             |
| 3. What types of modifications can be made in a classroom for children with hearing loss? | www.agbell.org                       |             |
|                                                                                  | www.cici.org                         |             |
| 4. How do cochlear implants work?                                                 |                                       |             |
| 5. Name some areas that can be affected by a learning disability?                  | www.idinfo.com                       |             |
| 7. What are the most common types of anxiety disorders in children?               | www.nmha.org/infoctr/               |             |
|                                                                                  | factsheets/index.cfm                 |             |
| 8. Name some multimodal treatments for AD/HD                                       | www.chadd.org/                       |             |
|                                                                                  | http://nichcy.org/pubs/              |             |
|                                                                                  | fact sheffs4txt.htm                  |             |
|                                                                                  | www.ndss.org                         |             |
|                                                                                  | www.ndsccenter.org                   |             |
|                                                                                  | www.downsyndrome.com                 |             |
| 10. Name some sensitivity that needs to be exhibited toward children with Tourette syndrome. | www.tsa-usa.org/                    |             |
|                                                                                  | www.tourettesyndrome.net/            |             |
| 12. What are some sports programs available to people with cerebral palsy?        | http://www.ucpa.org                  |             |

**Part II:** Choose a topic and design your own curriculum web. Limit to 5 questions.