# Dealing with Emotional, Behavioral and Physical Disabilities.
## (The teacher's challenge).

Divine Anjeh

Educating Learners with Diverse Needs

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Abstract

This paper addresses the differences between emotional and behavioral disorders, physical and health impairments and Traumatic brain Injury at the level of definitions, causes, and characteristics. It also describes specific and the most effective instructional strategies for students with these disabilities. It further suggests ways and means by which teachers could nurture self-esteem as well as self-advocacy skills for students with emotional disorders, physical/health impairments and traumatic brain injury. The paper will also posit on how teachers could get regular students to understand, respect and respond appropriately to other students with disabilities in an inclusion classroom before reporting on an IEP meeting the writer observed.

Emotional, Behavioral, and Physical Disabilities.

| **Factors** | **Emotional & Behavioral disorders** | **Physical & Health Impairments** | **Traumatic Brain Injury (TBI)** |
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| **Definition** | Emotional or behavioral disorders (EBD) refers to a condition in which behavioral or emotional responses of an individual in school are so different from his/her generally accepted, age-appropriate, ethnic, or cultural norms that they adversely affect educational performance in such areas as self-care, social relationships, personal adjustments, academic progress, classroom behavior, or work adjustment, (CECED, 1991)<br>The term includes children who are schizophrenic or autistic. The term does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed. | Physical disability or orthopedic impairment includes severe disabilities that adversely affect educational performance.<br>There is a diverse range of disabilities in this category including such conditions as cerebral palsy, spina bifida, amputations or limb absences, and muscular dystrophy | Traumatic brain injury is a head injury so severe that it damages the brain. Traumatic brain injury occurs when an injury to the exterior of the head is strong enough to cause damage to the brain. |
| **Causes** | Mental health disorders in children and adolescents are | There are many causes of physical disabilities. | Half of all traumatic brain injuries are caused by |

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| | caused by biology, environment, or combination of the two.<br>Some of the biological factors are genetics, chemical imbalances in the body, and damage to the central nervous system, such as a head injury.<br>Many environmental factors also can affect mental health, including exposure to violence, extreme stress, and the loss of an important person. | Neurological impairments, such as cerebral palsy, epilepsy, and spina bifida, cause damage to the brain and nervous system.<br>Musculoskeletal impairments, such as muscular dystrophy and arthritis, can reduce physical ability.<br>Toxins, drugs, or alcohol may cause other congenital defects. Trauma and illness (such as polio) are also leading causes of physical disabilities.<br>General causes of physical impairments and special health care needs are: infections Heredity, accidents and injuries, multiple factors etc. | collisions involving cars, motorcycles and bicycles. Traumatic brain injuries inflicted by firearms have the highest likelihood of causing death.<br>Infants and small children are also vulnerable to traumatic brain injuries, particularly as a result of being shaken violently.<br>The most common causes are motor vehicle and bicycle accidents, but can also include sports injuries, falls, or acts of violence, such as a gunshot wound or blow to the head. |
| **Characte -ristics** | a) an inability to learn which cannot be explained by intellectual, sensory or health factors; | These impairments make it difficult for children to control their voluntary motor | Children who sustain TBI may experience a complex array of problems, including the |

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| | b) an inability to build or maintain satisfactory relationships with peers and teachers;<br>c) Inappropriate types of behavior or feelings under normal circumstances;<br>d) a general pervasive mood of unhappiness or depression; or<br>e) a tendency to develop physical symptoms or fears associated with personal or school problems.<br>(IDEA, 1997). | movements; hence moving around will be difficult and challenging.<br>Intelligence is not affected by these conditions, though children will have had fewer opportunities to "act" on things in their environment.<br>Augmentative communication systems may be needed for children who have trouble speaking. Children should be encouraged to be independent in all activities. | following:<br>Physical impairments - speech, vision, hearing and other sensory impairment, headaches, lack of fine motor coordination, plasticity of muscles, paresis or paralysis of one or both sides and seizure disorders, balance, and other gait impairments.<br>**C**ognitive impairments - short- and long-term memory deficits, impaired concentration, slowness of thinking, and limited attention span, as well as impairments of perception, communication, reading and writing skills, planning, sequencing, and judgement.<br>Psychosocial-behavioral-emotional impairments - fatigue, mood swings, denial, self-centeredness, anxiety, depression, lowered self-esteem, sexual dysfunction, |

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| | | | restlessness, lack of motivation, inability to self-monitor, difficulty with emotional control, inability to cope, agitation, excessive laughing or crying, and difficulty relating to others. |

Traumatic Brain Injury

The strategies that teachers have used with success with students with disabilities are similar to those used with regular students. Hence all students benefit from these accommodations. To guarantee attention/concentration, which helps in the completion of task and the avoidance of the scenario wherein students fail to complete task because they are easily drawn into doing other things and neglecting their primary focus.

Lash (2000) suggests reducing distractions in students work area (i.e. removing extra books, pencils etc.); dividing work into smaller sections that will enable students complete one section at a suggested time and with specific expectations; asking students to summarize information that has just been presented orally; using cue cards to alert students to pay attention including words like “look,” ”listen,” or calling the student’s name); establishing a nonverbal cueing system like eye contact and touch to remind students to pay attention, as strategies that could be help in the classroom.

Another strategy for children with Traumatic Brain Injury (TBI) concentrates on training memory. It is believed that short-term memory is affected by TBI. To solve this, teachers may frequently repeat information or summarize it; encourage the use of post-it notes, calendars and assignment books; categorize and chunk up information to assist retention; link new information to students previous knowledge and experience; use mnemonics for easy recall; and provide experiential presentations of instructional

materials. These strategies would enhance the student's ability to mentally record and store information and be able to recall them from memory when needed.

TBI also impacts the child's ability to arrange information, materials and activities in an orderly manner. To help students whose organizational ability is affected by TBI, teachers should among other things provide students with additional time; provide checklist for complex tasks; write schedules and daily routines; review schedules daily and organize materials for each class; practice sequencing materials; make outlines based on class lectures; color-code materials for each class like textbooks, notebooks, and other supplies; and help plan activities like parties or after school events to strengthen their organizational skills.

The last set of strategies would address the issue of following directions by executing a series of steps to accomplish a given task. These skills would be trained by providing oral and written instructions; asking students to repeat instructions to the teacher or a peer; underlining and/or highlighting important parts of directions in written assignments; giving directions; asking students to perform task; checking accuracy and above all showing down the pace of instruction.

Emotional and Behavioral Disorders.

Students with Emotional and behavioral disorders reflect two major characteristics namely that their behavior is visibly different from that expected of the school or the community; and that they are in need of remediation. Teachers need to be sensitive and cautious in tackling students with these disorders.

The first strategy is to identify specific conduct that is disruptive and relate it to a particular behavior. When this is done, remediation is clearer. Lewis, Heflin, & DiGangi (1991) conclude that the most effective and efficient approach is to pinpoint the specific behavioral problem and apply data-based instruction for remediation.

Encouraging new behavior by focusing behavior management systems on positive, pro-social replacement will provide students with the opportunities to practice and be reinforced for appropriate behaviors.

Among the many strategies suggested by research students should provide adequate opportunities for students to practice new behaviors by structuring the learning environment so that these skills can be addressed and practiced. The pro-social behaviors

would include taking turns, working with a partner, working in groups, or with others; displaying appropriate behaviors toward peers; increasing positive relationships; showing interest and caring; setting conflicts without fighting, (Algozine, Ruhl, & Ramsey, 1991).

Another common strategy is the one that considers social skills deficits as errors in learning. Addressing situations that verify students' reaction in social situations like how would you behave if a peer on the bus calls you a name? Role-playing responses in several social situations would help address many social deficits.

*Physical and Health Impairments.*

Most accommodations for the physically impairment would deal with the provision of certain accommodations and making learning as well as the learning environment accessible. Usually schoolchildren may require special features and instructional accommodations including adjusted schedules and extra time, planning for health care in the classroom in order to respond to emergencies such as seizures and for monitoring medication.

Other strategies would include creative solutions (e.g., videotapes of lessons) to lessen the impact of absences, which are a common feature of classrooms for the physical and health impaired considering their frequent health lapses as well as their frail situation.

Moreover the teacher has to be knowledgeable and received training in issues including lifting and transferring children, and coordination of professional services. He also has to be able to adapt to specific physical environments. This he can do by reducing the amount of furniture and equipment in the classroom for the blind or vision impaired for example or the amount of distractions at the reach of students with ADHD.

Therefore, learning environments should be redesigned, and that task could become an excellent learning activity. Accessibility and inclusion is important at school, at home, and in the community. Removal of physical barriers, elimination of social barriers, participation in extracurricular activities, inclusion in sports and leisure time activities are strategies teachers could use to good effect with students with disabilities.

Modifying teaching techniques is at the center of strategies that would help students who are physically or health impaired. It should include a lot of visuals, realia for some and audio for others. Teachers should provide interactive group activities as

well as experiential instruction which offer students a practical way of accessing content. Providing content in moderated chunks would reduce distraction; in the same way as slowing down instruction would improve comprehension.

*Improving self-esteem and self-advocacy.*

Allowing the students assume responsibility for their own learning in a positive way to improve their self-concept, feeling of belonging to the school, and success at school. Common strategies would include those involving self-control, self-reinforcement, self-monitoring, self-management, problem, problem-solving, cognitive behavior modification, and metacognitive skills focus primarily on teaching students the skills necessary for taking responsibility and showing initiative in making decisions about their own instruction.

In most cases students with disabilities are treated as different from other students. This usually alienates and isolates them leading them to deliberately avoiding contact with regular kids, who make fun of them. One of the things teachers can do is help peers understand, accept and include those with difference, (CSWD, 2002).

Promoting inclusionary practices will also enable disabled and nondisabled children follow normal routines providing opportunities for them to recognize the many similarities they share; the talents and abilities of every classmate; and to accept or even celebrate the unique traits that make each person an individual.

Nurturing respect and understanding

It is believed that this contact between children will begin to “break down barriers of misunderstandings and dispel the myths that have created society’s and their own response to disability,” (Kliff & Kunc, 1994).

Dembo & Wright (1983) insists that help should always be “natural and situation-rooted.” The fear is that in most classrooms, regular kids have the tendency of trying to do everything for students with disabilities. The issue here is that too much help is disempowering and as much as it teaches other students to be respectful of students with disability, it deprives them of the important opportunity to develop independently.

Most children with disability are cautious of what is fair and what is not. They feel the weight of the stigma they are forced to carry around every day. It is important

that teachers insist on behaviors and practices, especially from their peers, to alleviate the feeling that they are disregarded, isolated, rejection etc.

Venn (1989) warns that we must take care not to inadvertently reinforce the notion that those with disabilities are objects of pity. Talking to kids about the effects of segregation or even getting them role-play situations like “what it’s like to be blind?” may unintentionally result in more distance and a greater sense of fundamental ‘otherness.’

*The IEP Meeting*

The meeting started with the completing of demographic forms. The form collected data on name, age, grade, school district, primary language of communication and an indication of the education decision maker, case manager information, date of meeting and projected day of the next day of review. Present were a parent, IEP Case Manager, two general education teachers, a Special Education teacher, a school counselor and a translator.

The teachers presented a picture of the child’s present level of academic achievement and functional performance. The concentration was in areas where the child’s apparent disability affected his involvement and progress in the general curriculum as well as his social behavior. The two classroom teachers provided input by supplying information on the strengths of the child; changes in the current functioning of the child since the initial IEP; a review; a summary of his most recent degree of success.

The IEP meeting provided a forum for all parties to listen to information from each other and an opportunity for the parent to share information about her child. Teachers were also able to share their thoughts, concerns and recommendations. It presented the parents the opportunity to exercise their rights of determining or taking decisions about their child.

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