Children whose behavior deviates from society’s standards for normal behavior for certain ages and stages of development are identified as having disabilities. Behavioral expectations vary from setting to setting; for example, yelling on the football field is acceptable, but yelling when the teacher is explaining a lesson to the class is not. Different cultures have different standards of behavior, further complicating the question of what constitutes a behavioral problem. People also have their personal opinions and standards for what is tolerable and what is not. Some behavioral problems are openly expressed; others are inwardly directed and not very obvious. As a result of these factors, the terms behavioral disorders and emotional disturbance have become almost interchangeable.

While almost all children at times exhibit behaviors that are aggressive, withdrawn, or otherwise inappropriate, the IDEA definition of serious emotional disturbance (SED) focuses on behaviors that persist over time, are intense, and impair a child’s ability to function in society. The behaviors must not be caused by temporarily stressful situations or other factors such as depression over the death of a grandparent or anger over the parents’ impending divorce. In order for a child to be considered seriously emotionally disturbed, he or she must exhibit one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child’s educational performance.

- Inability to learn that cannot be explained by intellectual, sensory, or health factors
- Inability to maintain satisfactory interpersonal relationships
- Inappropriate types of behaviors
- General pervasive mood of unhappiness or depression
- Physical symptoms or fears associated with personal or school problems

Schizophrenic children are covered under this definition, and social maladjustment by itself does not satisfy this definition unless it is accompanied by one of the other conditions of SED.

The diagnostic categories and definitions used to classify mental disorders come from the American Psychiatric Association’s publication Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), the handbook used by psychiatrists and psychologists. The DSM-IV is a multiaxial classification system consisting of dimensions (axes) coded along with the psychiatric diagnosis. The axes are listed below.
### Axis I
Principal psychiatric diagnosis (e.g., overanxious disorder)

### Axis II
Developmental problems (e.g., developmental reading disorder)

### Axis III
Physical disorders (e.g., allergies)

### Axis IV
Psychosocial stressors (e.g., divorce)

### Axis V
Rating of the highest level of adaptive functioning (includes intellectual and social). Rating is called Global Assessment Functioning (GAF) score.

While the DSM-IV diagnosis is one way of diagnosing SED, there are other ways of classifying the various forms in which behavior disorders manifest themselves. The following tables summarize some of these classifications.

<table>
<thead>
<tr>
<th>Externalizing Behaviors</th>
<th>Internalizing Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggressive behaviors expressed outwardly toward others</td>
<td>Withdrawing behaviors that are directed inward to oneself</td>
</tr>
<tr>
<td>Manifested as hyperactivity, persistent aggression, irritating behaviors that are impulsive and distractible</td>
<td>Social withdrawal</td>
</tr>
<tr>
<td>Examples: hitting, cursing, stealing, arson, cruelty to animals, hyperactivity</td>
<td>Depression, fears, phobias, elective mutism, withdrawal, anorexia, and bulimia</td>
</tr>
</tbody>
</table>

Well-known instruments used to assess children’s behavior have their own categories and scales to classify behaviors. The following table illustrates the scales used in some of the widely used instruments.

<table>
<thead>
<tr>
<th>Walker Problem Identification Checklist</th>
<th>Burks’ Behavior Rating Scales (BBRS)</th>
<th>Devereux Behavior Rating Scale (Adolescent)</th>
<th>Revised Behavior Problem Checklist (Quay &amp; Peterson)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acting out</td>
<td>Excessive self-blame</td>
<td>Unethical behavior</td>
<td><strong>Major scales</strong></td>
</tr>
<tr>
<td>Withdrawal</td>
<td>Excessive anxiety</td>
<td>Defiant-resistant</td>
<td>Conduct Disorder</td>
</tr>
<tr>
<td>Distractibility</td>
<td>Excessive withdrawal</td>
<td>Domineering-sadistic</td>
<td>Socialized aggression</td>
</tr>
<tr>
<td>Disturbed peer relations</td>
<td>Excessive dependency</td>
<td>Heterosexual interest</td>
<td>Attention problems—immaturity</td>
</tr>
</tbody>
</table>

*Continued on next page*
## Development and Characteristics of Learners

### Walker Problem Identification Checklist

<table>
<thead>
<tr>
<th>Walker Problem Identification Checklist</th>
<th>Burks’ Behavior Rating Scales (BBRS)</th>
<th>Devereux Behavior Rating Scale (Adolescent)</th>
<th>Revised Behavior Problem Checklist (Quay &amp; Peterson)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immaturity</td>
<td>Poor ego strength</td>
<td>Hyperactive expansive</td>
<td>Anxiety—withdrawal</td>
</tr>
<tr>
<td>Poor physical strength</td>
<td>Poor emotional control</td>
<td>Poor intellectuality</td>
<td>Minor scales</td>
</tr>
<tr>
<td>Poor coordination</td>
<td>Need approval, dependency</td>
<td>Poor intellectuality</td>
<td>Psychotic behavior</td>
</tr>
<tr>
<td>Poor intellectuality</td>
<td>Emotional disturbance</td>
<td>Poor intellectuality</td>
<td>Motor excess</td>
</tr>
<tr>
<td>Poor academics</td>
<td>Physical inferiority—timidity</td>
<td>Poor academics</td>
<td></td>
</tr>
<tr>
<td>Poor attention</td>
<td>Schizoid withdrawal</td>
<td>Poor attention</td>
<td></td>
</tr>
<tr>
<td>Poor impulse control</td>
<td>Bizarre speech and cognition</td>
<td>Excessive suffering</td>
<td></td>
</tr>
<tr>
<td>Poor reality contact</td>
<td>Bizarre actions</td>
<td>Poor sense of identity</td>
<td></td>
</tr>
<tr>
<td>Poor sense of identity</td>
<td></td>
<td>Excessive suffering</td>
<td></td>
</tr>
<tr>
<td>Excessive suffering</td>
<td></td>
<td>Poor anger control</td>
<td></td>
</tr>
<tr>
<td>Excessive sense of persecution</td>
<td></td>
<td>Excessive aggressiveness</td>
<td></td>
</tr>
<tr>
<td>Excessive aggressiveness</td>
<td></td>
<td>Excessive resistance</td>
<td></td>
</tr>
</tbody>
</table>

Disturbance may also be categorized in degrees: mild, moderate, or severe. The degree of disturbance will affect the type and degree of interventions and services required by the student with an emotional disturbance. Degree of disturbance also must be considered when determining the least restrictive environment and the services named for free, appropriate education for these students. An example of a set of criteria for determining the degree of disturbance is the one developed by P. L. Newcomer:
<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>MILD</th>
<th>MODERATE</th>
<th>SEVERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precipitating Events</td>
<td>Highly stressful</td>
<td>Moderately stressful</td>
<td>Not stressful</td>
</tr>
<tr>
<td>Destructiveness</td>
<td>Not destructive</td>
<td>Occasionally destructive</td>
<td>Usually destructive</td>
</tr>
<tr>
<td>Maturational Appropriateness</td>
<td>Behavior typical for age</td>
<td>Some behavior untypical for age</td>
<td>Behavior too young or too old</td>
</tr>
<tr>
<td>Personal Functioning</td>
<td>Cares for own needs</td>
<td>Usually cares for own needs</td>
<td>Unable to care for own needs</td>
</tr>
<tr>
<td>Social Functioning</td>
<td>Usually able to relate to others</td>
<td>Usually unable to relate to others</td>
<td>Unable to relate to others</td>
</tr>
<tr>
<td>Reality Index</td>
<td>Usually sees events as they are</td>
<td>Occasionally sees events as they are</td>
<td>Little contact with reality</td>
</tr>
<tr>
<td>Insight Index</td>
<td>Aware of behavior</td>
<td>Usually aware of behavior</td>
<td>Usually not aware of behavior</td>
</tr>
<tr>
<td>Conscious Control</td>
<td>Usually can control behavior</td>
<td>Occasionally can control behavior</td>
<td>Little control over behavior</td>
</tr>
<tr>
<td>Social Responsiveness</td>
<td>Usually acts appropriately</td>
<td>Occasionally acts appropriately</td>
<td>Rarely acts appropriately</td>
</tr>
</tbody>
</table>


To effectively assess and plan for the developmental needs of individuals with disabilities, developmental areas of speech and language, fine and gross motor skills, cognitive abilities, emotional development, and social skills should be considered. In many cases, more than one area of development will be affected by a disability. In others, a problem that can be the result of a disability is actually the result of some normal factor in development. These things must be taken into consideration when interpreting a child’s behavior and needs.

**LANGUAGE**: the means whereby people communicate their thoughts, make requests, and respond to others.

**COMMUNICATION COMPETENCE**: the interaction of cognitive competence, social knowledge, and language competence.

Communication problems can occur in any or all of these areas and have a direct impact on the student’s ability to interact with others. Language consists of several components, each of which follows a sequence of development.
Brown and colleagues were the first to describe language as a function of developmental stages rather than age (Reid, 1988, p. 44). They developed a formula to group the mean length of utterances (sentences) into stages. Counting the number of morphemes per one hundred utterances, one can calculate a mean length of utterance (MLU). Total number of morphemes / 100 = MLU, e.g., 180/100 = 1.8.

<table>
<thead>
<tr>
<th>Stage</th>
<th>MLU</th>
<th>Developmental Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>L</td>
<td>1.5–2.0</td>
<td>14 basic morphemes (e.g., in, on, articles, possessives)</td>
</tr>
<tr>
<td>LI</td>
<td>2.0–2.5</td>
<td>Beginning of pronoun use, auxiliary verbs</td>
</tr>
<tr>
<td>LII</td>
<td>2.5–3.0</td>
<td>Language forms approximate adult forms; beginning of questions and negative statements</td>
</tr>
<tr>
<td>IV</td>
<td>3.0–3.5</td>
<td>Use of complex (embedded) sentences</td>
</tr>
<tr>
<td>V</td>
<td>3.5–4.0</td>
<td>Use of compound sentences</td>
</tr>
</tbody>
</table>

**Components of Language**

Language learning is composed of five components: phonology, morphology, syntax, semantics, and pragmatics. Developmentally, children progress through each component.

**Phonology**

**PHONOLOGY** is the system of rules about sounds and sound combinations for a language. A phoneme is the smallest unit of sound that combines with other sounds to make words. Most phonemes have no meaning in isolation (“a” and “I” are exceptions). Generally, a phoneme must be combined with other phonemes to compose words or other morphemes. Problems in phonology may be manifested as developmental delays in acquiring consonants, reception problems such as misinterpreting words because a different consonant was substituted, or difficulty learning the sound-symbol code (phonics).

**Morphology**

**MORPHEMES** are the smallest units of language that convey meaning or function. **FREE MORPHEMES** are morphemes that can stand alone as root words, such as *walk* or *dog*. **BOUND MORPHEMES** are morphological units that do not stand alone. They convey or alter meaning when attached to other morphemes. Prefixes and
Suffixes (e.g., pre-, -less), and inflectional endings (-ed, -ing) are examples of bound morphemes. **Morphology** is composed of all the rules for making words, including rules for making plurals, possessives, and inflections in verbs. **Content words** carry the meaning in a sentence, and **functional words** join phrases and sentences. Generally, students with problems in this area may not use inflectional endings in their words, may not be consistent in their use of certain morphemes, or may be delayed in learning such morphemes as are used in irregular past tenses.

**Syntax**

**Syntax Rules**, commonly known as grammar, govern how morphemes and words are correctly combined to make sentences. Wood (1976, p.115) describes six stages of syntax acquisition.

- **Stage 1 and 2** (birth to about 2 years): Child is learning the semantic system.
- **Stage 3** (ages 2 to 3 years): Simple sentences contain subject and predicate.
- **Stage 4** (ages 2½ to 4 years): Elements such as question words (e.g., where) are added to basic sentences; word order is changed to ask questions. The child begins to use and combine simple sentences and to embed words within the basic sentence.
- **Stage 5** (about 3½ to 7 years): The child uses complete sentences that include word classes of adult language. The child is becoming aware of appropriate semantic functions of words and differences within the same grammatical class.
- **Stage 6** (about 5 to 20 years): The child begins to learn complex sentences and sentences that imply commands, requests, and promises.

**Semantics**

**Semantics** is language content: the linguistic meaning of morphemes, words, phrases, and sentences. As with syntax, Wood (1976) outlines stages of semantic development:

- **Stage 1** (birth to about 2 years): The child is learning meaning while learning his first words. Sentences are one word, but the meaning varies according to the context. Therefore, *doggie* may mean “This is my dog,” “There is a dog,” or “The dog is barking.”
- **Stage 2** (about 2 to 8 years): The child progresses to two-word sentences about concrete actions. As more words are learned, the child forms
longer sentences. Until about age seven, items are defined in terms of visible actions. The child begins to respond to prompts (e.g., pretty/flower); at about age eight, the child can respond to a prompt with an opposite (e.g., pretty/ugly)

- **Stage 3 (begins at about age 8):** The child’s word meanings relate directly to experiences, operations, and processes. Vocabulary is defined by the child’s experiences, not the adult’s. At about age twelve, the child begins to give dictionary definitions, and the semantic level approaches that of adults.

Semantic problems take the form of the following:
- Limited vocabulary
- Inability to understand figurative language or idioms; interprets literally
- Failure to perceive multiple meanings of words, changes in word meaning from changes in context, resulting in incomplete understanding of what is read
- Difficulty understanding linguistic concepts (e.g., before/after), verbal analogies, and such logical relationships as possessives, spatial, and temporal
- Misuse of transitional words such as although, regardless

**Pragmatics**

Commonly known as the speaker’s intent, **pragmatics** are used to influence or control the actions or attitudes of others. **COMMUNICATIVE COMPETENCE** depends on how well one understands the rules of language and such social rules of communication as taking turns and using the correct tone of voice.

Pragmatic deficits are manifested by failures to respond properly to indirect requests after age eight (e.g., “Can’t you turn down the TV?” elicits a response of “No” instead of “Yes” and the child turning down the volume). Children with these deficits have trouble reading cues that indicate the listener does not understand them. Whereas a person would usually notice this and adjust one’s speech to the listener’s needs, the child with pragmatic problems does not do this.

Pragmatic deficits are also characterized by inappropriate social behaviors such as interruptions or monopolizing conversations. Children may use immature speech and have trouble sticking to a topic. These problems can persist into adulthood, affecting academic, vocational, and social interactions.

Problems in language development often require long-term interventions and can persist into adulthood. Certain problems are associated with different grade levels.

**Preschool and Kindergarten**

The child’s speech may sound immature. The child may not be able to follow simple directions and often cannot name such concepts as the days of the week.
and colors. The child may not be able to discriminate between sounds and the letters associated with the sounds. The child might substitute sounds and have trouble responding accurately to certain types of questions. The child may play less with his peers or participate in nonplay or parallel play.

**Elementary school**

Problems with sound discrimination persist, and the child may have problems with temporal and spatial concepts such as before and after. As the child progresses through school, he or she may have problems making the transition from narrative to expository writing. Word retrieval problems may not be very evident because the child begins to devise strategies such as talking around the word he cannot remember or using fillers and descriptors. The child might speak more slowly, have problems sounding out words, and get confused with multiple-meaning words. Pragmatic problems such as failure to correctly interpret social cues and adjust to appropriate language, inability to predict consequences, and inability to formulate requests to obtain new information show up in social situations.

**Secondary school**

At this level, difficulties become more subtle. The child cannot use and understand higher-level syntax, semantics, and pragmatics. If the child has problems with auditory language, he may also have problems with short-term memory. Receptive and expressive language delays impair the child’s ability to learn effectively. The child often cannot organize and categorize the information received in school. Problems associated with pragmatic deficiencies persist but, because the child is aware of them, he becomes inattentive, withdrawn, or frustrated.

**Physical Development, Including Motor and Sensory Development**

It is important for the teacher to be aware of the physical stages of development and how the child’s physical growth affects the child’s learning. In general, a child’s physical abilities develop downward, from head to toe, and outward from the torso or central body mass to the extremities. In normal development, both gross motor (large body movements) and fine motor (small, precise body movements) develop together.

From an educational standpoint, children are generally assumed to have met the following gross motor milestones by the time they enter first grade:

- Locomotion such as hopping, running, skipping, jumping, and sliding
- Alternating or moving from one gross motor activity to another in a regular pattern
- Motor activities with an object or ball, such as kicking, throwing, or catching
• Motor activities involving simple tumbling exercises, such as somersaults
• Moving to a simple rhythm or beat

Fine motor skills considered necessary for success in first grade include such things as:
• Establishment of hand dominance
• “Pincer grasp” or using finger(s) and thumb to pinch something
• Some variation of the “tripod grasp” of a pencil or writing implement
• Ability to cut out large, irregular patterns in paper
• Ability to draw a reasonable representation of a circle, square, triangle, person (with legs, arms, face) and a house
• Ability to use both hands jointly for a task such as unscrewing a lid or putting two Lego blocks together
• Assembling large interlocking puzzle pieces
• Clothing skills such as buttoning, unbuttoning and tying shoelaces

In addition to motor disorders, individuals with physical disabilities may have multidisabling conditions such as concomitant hearing impairments, visual impairments, perceptual disorders, speech defects, behavior disorders, or mental handicaps, performance, and emotional responsiveness.

Cognitive Development
Children go through patterns of learning, beginning with preoperational thought processes, and then moving on to concrete operational thoughts. Eventually, they begin to acquire the mental ability to think about and solve problems in their heads because they can manipulate objects symbolically. Even when children reach a stage where they can use symbols such as words and numbers to represent objects and relations, they will persist in needing concrete reference points for some time. It is essential that children be encouraged to use and develop the thinking skills they possess in solving problems that interest them. The content of the curriculum must be relevant, engaging, and meaningful to the students.

Some common features indicating a progression from more simple to more complex cognitive development include the following:

Children (ages 6-12)
Children begin to develop the ability to think in concrete ways. Concrete operations are those performed in the presence of the object and events that are to be
used. Examples include knowing how to combine (addition), separate (subtract or divide), order (alphabetize and sort/categorize), and transform objects and actions (change things such as 25 pennies to 1 quarter).

Adolescents (ages 12-18)
Adolescence marks the beginning of the development of more complex thinking skills, including abstract thinking, the ability to reason from known principles (form own new ideas or questions), the ability to consider many points of view according to varying criteria (compare or debate ideas or opinions), the ability to see things from different perspectives, and the ability to think about the process of thinking. The transition from concrete thinking to formal logical operations occurs over time. Each adolescent progresses at varying rates in developing his or her ability to think in more complex ways and develops his or her own view of the world. Some adolescents may be able to apply logical operations to schoolwork long before they are able to apply them to personal dilemmas. When emotional issues arise, they often interfere with an adolescent’s ability to think in more complex ways. The ability to consider possibilities as well as facts may influence decision making in either positive or negative ways.

No two students are alike, so it follows that no students learn alike. To apply a one-dimensional instructional approach is to impose learning limits on students. A teacher must acknowledge the variety of learning styles and abilities among students, and apply multiple instructional methods to ensure that every child has appropriate opportunities to master the subject matter, demonstrate such mastery, and improve learning skills with each lesson.

Differentiated Instruction
In recent years, increasing emphasis has been put on incorporating at least some principles of differentiated instruction into classrooms with students of mixed ability. Tomlinson (2001) states that teachers must first determine where the students are with reference to an objective, then tailor specific lesson plans and learning activities to help each student learn as much as possible about that objective. The effective teacher seeks to connect all students to the subject matter through multiple techniques, with the goal that each student will relate to one or more techniques and excel in the learning process. This is particularly relevant to
instruction of students with disabilities. Differentiated instruction encompasses modifying curriculum in several areas.

- **Content**: What is the teacher going to teach? Or, perhaps better put, what does the teacher want the students to learn? Differentiating content means that students have access to aspects of the content that pique their interest, with a complexity that provides an appropriate challenge to their intellectual development, but does not go beyond their frustration level.

- **Process**: The classroom management techniques through which instructional organization and delivery are maximized for the diverse student group. These techniques should include dynamic, flexible grouping activities, where instruction and learning occur as whole-class, teacher-led activities and in a variety of small group settings, such as teacher-guided small group, peer learning and teaching (while teacher observes and coaches), or independent centers or pairs.

- **Product**: The expectations and requirements placed on students to demonstrate their knowledge or understanding. The type of product expected from each student should reflect that student’s own capabilities.

**Promoting Motivation**

Before instruction begins, meaningful and relevant activities should be chosen, and should be appropriately leveled in terms of difficulty. This is particularly effective for students with disabilities, who are more likely to act out when demands are beyond their ability to meet. Teacher behaviors that motivate students include:

- Maintain success expectations through teaching, goal setting, establishing connections between effort and outcome, and self-appraisal and reinforcement.

- Have a supply of intrinsic incentives such as rewards, appropriate competition between students, and the value of the academic activities.

- Focus on students’ intrinsic motivation through adapting the tasks to students’ interests, providing opportunities for active response, using a variety of tasks, providing rapid feedback, incorporating games into the lesson, and allowing students the opportunity to make choices, create, and interact with peers.

- For some students with disabilities, extrinsic rewards and token systems (prize charts, etc.) may be necessary. Often the student’s IEP will specify use of such tools.

- Stimulate students’ learning by modeling positive expectations and attributions. Project enthusiasm and personalize abstract concepts. Students will be better motivated if they know what they will be learning. The teacher should
also model problem-solving and task-related thinking so students can see how the process is done.

For adolescents, motivation strategies are usually aimed at getting the student actively involved in the learning process. Since the adolescent has the opportunity to get involved in a wider range of activities outside the classroom (e.g., job, car, being with friends), stimulating motivation may be the focus even more than academics.

Motivation may be improved by allowing the student a degree of choice in what is being taught or how it will be taught. The teacher will, if possible, obtain a commitment either through a verbal or written contract between the student and the teacher. Adolescents also respond to regular feedback, especially when that feedback shows they are making progress.

### SPECIFIC LEARNING DISABILITIES

| Central Auditory Processing Deficit (CAPD) | Students with CAPDs have normal hearing *physiologically*, but have deficits in the processing or auditory input. Such deficits impact both cognitive and linguistic functioning in both receptive and expressive modes. The symptoms sometimes are mistaken for ADHD because the child cannot adequately process instructions and information. |
| Communication Disorders | This group includes deficits in language processing, articulation, fluency, or voice. |
| Dyscalculia | Any serious disability in processing mathematical information, concepts, or calculations, particularly when there are not corresponding disabilities in other verbal skills. |
| Dysgraphia | A serious deficit in the ability to carry out the motor or cognitive functions necessary to write. This may be a motor problem and/or a cognitive inability to plan and generate sentences. It is usually neurologically based. |

The previous classification system is useful when defining eligibility for special services and placement in special service programs. The following tables demonstrate traits and characteristics of “Specific Learning Disabilities” and “Diagnoses of Children with Special Needs.” It is important for the teacher to understand the terminology of these disabilities when applied to his or her students.
Dyslexia

Although this term is not as widely used as it once was, it still refers to a reading disability that is based in problems learning to associate sounds and symbols (letters).

Nonverbal Learning Disabilities

These disabilities impact many areas of nonverbal problem solving. Although children with them can often “read” and memorize well, they have significant difficulty understanding what they read, as well as difficulty understanding nonverbal communication such as facial expressions and body language. As a result, both social competence and emotional well-being can be impacted. There may also be deficits in visual-spatial organization and motor control.

Pervasive Developmental Disorders Not Otherwise Specified (PDDNOS)

These disorders are very similar to autism and are sometimes referred to as “autism spectrum disorders.” Though children with these disorders do not qualify as autistic, they have many of the same deficits in social and communication skills.

In addition to specific learning disabilities, special education teachers may often encounter the following diagnoses of children with special needs.

### DIAGNOSES OF CHILDREN WITH SPECIAL NEEDS

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention Deficit Disorder (ADD) or Attention Deficit with Hyperactivity Disorder (ADHD)</td>
<td>Children with these disorders display serious inattention, distractibility, disorganization, and poor impulse control, often with constant movement or activity they cannot control. Typically, they do not show delayed cognition or mental retardation. These disorders can often accompany other medical or learning disorders, however, and further impact learning.</td>
</tr>
<tr>
<td>Asperger’s Syndrome</td>
<td>Although the definition of this disorder is changing in some quarters, it usually refers to a type of autism involving most of the characteristics of autism, without cognitive delay or retardation. Children with this disorder have normal or above average cognitive abilities. It is often referred to as a “high functioning form of autism.”</td>
</tr>
<tr>
<td>Cerebral Palsy</td>
<td>This is a neurological disorder that involves damage to the motor centers of the brain (during fetal development, or during or after birth) and results in tremors and muscle weakness or tension. Both gross and fine motor skills can be affected.</td>
</tr>
<tr>
<td>Developmental Disabilities</td>
<td>These disabilities result in significant delays in physical (e.g., Cerebral Palsy) or cognitive (mental retardation) abilities.</td>
</tr>
<tr>
<td>Tourette Syndrome</td>
<td>This is a seizure disorder (not epilepsy) that produces motor, vocal, and other tics (i.e., highly repetitive actions) over which the child has minimum control.</td>
</tr>
</tbody>
</table>

*See Skill 5.1 for Federal Definitions.*
An exceptionality may have a positive, negative, or neutral effect throughout a child’s life, depending on the characteristics of the exceptionality, available resources, and support system.

**Early Childhood**

Often the life of a child with an exceptionality will be different beginning at birth. The child may experience marked developmental delays in some areas and not in other areas. The child’s exceptionality may have negative and positive effects on siblings. Some siblings may have feelings of embarrassment, resentfulness, or even guilt related to their sibling with a disability. Other siblings may gain insight, tolerance, and appreciation because of their experience with the sibling with the exceptionality.

The child with the exceptionality may require special diets, transportation, medical care, and other special services. These requirements may cause financial stress on the family.

**School Age**

Academic and social skills are crucial at this age. The goal during this age is to prepare the child to be an independent, productive citizen. A child with an exceptionality may or may not experience a difficult time interacting with others. If these skills are not taught, this deficiency may cause the child difficulty in developing relationships and future employment problems.

Having an exceptionality may or may not limit a child’s academic ability. The goal of the educational system is to include students with exceptionalities in the general education curriculum as much as possible. The degree of inclusion in the curriculum is based on each student’s ability.

In the teen years, when young people are beginning to express their individuality, the very appearance of walking into a special education classroom can bring feelings of inadequacy, as well as labeling by peers that the student is “special.” Being considered normal is the desire of almost all individuals with disabilities, regardless of the age or disability. People with disabilities today, as many years ago, still measure their successes by how their achievements mask or hide their disabilities.

During this time in life, the student and other concerned individuals collaborate to decide on the child’s future and how the student will transition into the next phase of life. Depending on the characteristics of the child’s exceptionality, it may
be decided that the student will attend technical school, attend post-secondary education, or begin working.

**Adult**

An adult with an exceptionality may or may not lead a life that is different from any other adult. The adult may go to work every day and come home to take care of all of his or her own needs. Another adult with an exceptionality may live with a caregiver. Adults with exceptionalities have various living options, ranging from residential homes to a very restricted environment, such as institutions.

Many outside agencies provide services for those adults who may need assistance.

Some adults may still lack social skills to maintain a healthy work environment; therefore, job coaches, mentors, or outside agencies are needed to provide additional assistance or needed work skills.

Adults who lack social skills may also have difficulty finding mates and may never have families, while others may find mates and raise families of their own with no outside assistance.

**SKILL 1.5 Impact of language, cultural, and gender differences on the identification process**

Students are more than the sum of the effects of their disabilities. Cultural, linguistic, and gender characteristics also help define the student, and these characteristics must be taken into account for instructional planning.

Just as cultures place varying values on education and the role of genders, different views may also be taken of individuals with disabilities, including appropriate education, career goals, and the individual’s role in society. The special needs educator must first become familiar with the cultural representations of the students and the community in which he or she teaches. As the special needs educator demonstrates respect for each individual student’s culture, he or she will build the rapport necessary to work with the student, family, and community to prepare the student for future productive work, independence, and possible post-secondary education or training (IDEA 2004).

The educational experience for most students is a complex experience with a diversity of interlocking meanings and inferences. If one aspect of the complexity is altered, it affects other aspects, which may have an impact on how a student or teacher views an instructional or learning experience. With the current
demographic profile of today’s school communities, the complexity of understanding, interpreting, and synthesizing nuances from the diversity of cultural lineages can provide many communication and learning impediments that could hamper the acquisition of learning, especially for students with exceptionalities.

Teachers must create **PERSONALIZED LEARNING COMMUNITIES** where every student is a valued member of and contributor to the classroom experiences. In classrooms where sociocultural attributes of the student population are incorporated into the fabric of the learning process, dynamic interrelationships are created that enhance the learning experience and the personalization of learning.

Similarly, inclusion of students with exceptionalities into the general education classroom can be beneficial for advanced academic achievement as well as sociocultural development, provided proper accommodations for their special needs are made. Researchers continue to show that personalized learning environments increase learning for students, decrease drop-out rates among marginalized students, and decrease unproductive student behavior that can result from constant cultural misunderstandings or miscues between students.

Learning environments that help children with and without disabilities understand that both learning abilities and styles differ, and that each child has a place in and something to contribute to the group can prevent misunderstandings and intolerance of students with special needs. Promoting diversity of learning and cultural competency in the classroom creates a world of multicultural opportunities and learning. When students are able to step outside their comfort zones and share the world of a homeless student or empathize with an English language learner (ELL) who has just immigrated to the United States, is learning English for the first time, and is still trying to keep up with the academic learning in an unfamiliar language, then students grow exponentially in social understanding and cultural connectedness.

Personalized learning communities provide supportive learning environments that address the academic and emotional needs of all students. As sociocultural knowledge is conveyed continuously in the interrelated experiences shared cooperatively and collaboratively in student groupings and individualized learning, the current and future benefits will continue to present the case and importance of understanding the whole child, inclusive of the social and cultural context.

**Gender**

More boys are identified as having emotional and behavioral problems, especially hyperactivity and attention deficit disorder, autism, childhood psychosis, and problems with poor control (aggression, socialized aggression). Girls, on the other hand, have more problems with overcontrol (withdrawal and phobias). Problems
with mental retardation and language and learning disabilities are much more prevalent in boys than in girls.

Gender may also create sensitive issues, since some cultures and sub-cultural groups have very specific and distinct ideas about appropriate male and female roles in society. These ideas may impact what is considered an appropriate functional skill. Some cultural groups, for example, consider family food preparation and cooking to be appropriate skills for women, but not for men. Regardless of whether the teacher agrees with a view or not, it is the teacher’s responsibility to take it into consideration when designing instruction. In all cases, the planned method of instruction, as well as any materials used, must be culturally sensitive, as well as practically effective.

Children who have multiple disabilities are an extremely heterogeneous population. Their characteristics are determined by the type and severity of their combined disabilities; therefore, they differ in their sensory, motor, social, and cognitive abilities. Although any number of combinations of disabilities is possible, major dimensions typically include mental retardation, neurological impairments, emotional disturbance, or deafness and blindness. Those whose impairments combine to form multiple disabilities often exhibit characteristics on a severe level. Low self-esteem and poor social skills often characterize this population. Youngsters with severe disabilities may possess profound language or perceptual-cognitive deprivations. Moreover, they may have extremely fragile physiological conditions. “It is important to understand that (with) the problem of severe/profound disabilities…It is the extent of the disabilities that results in the child’s classification, not the type of disabilities” (Blackhurst & Berdine, 1985, pp. 473–474).

Some characteristics students with severe or profound multidisabilities have are:

- Often not toilet trained
- Frequently nonambulatory
- Aggressiveness toward others without provocation and antisocial behavior
- Markedly withdrawn or unresponsive to others
- No attention to even the most pronounced social stimuli
- Self-mutilation (head banging, biting, and scratching or cutting of self)
• Rumination (self-induced vomiting, swallowing vomitus)
• Self-stimulation (rocking, hand-flapping)
• Intense temper tantrums of unknown origin
• Excessive, pointless imitation, or the total absence of the ability to imitate
• Inability to be controlled verbally
• Extremely brittle medical existence (life-threatening conditions such as congenital heart disease, respiratory difficulties, metabolic disorders, central nervous system disorders, and digestive malfunctions)

There are times when an exceptional student has a disability coupled with a behavioral issue. In order to tackle the issue of behavior problems, educators usually start with a Behavior Intervention Plan (BIP). One of the first steps to developing a BIP entails taking a detailed FUNCTIONAL BEHAVIOR ASSESSMENT (FBA) summary, which must define behaviors in observable and measurable terms along four variables: frequency, duration, intensity, and degree of severity.

The FBA must note the frequency of the behaviors that have been identified. Frequency consists of how often a behavior occurs in a specified time block (e.g. morning, afternoon, evening). The activity during which the behavior typically occurs is also recorded. For example, does it occur during lunch, transitions, group time, or another time period? The data should indicate the frequency of the individual behaviors and note when it is less frequent and when the behavior is most likely to occur.

The FBA can help identify the following:
• When the behavior was first observed and key events at that time
• Any signs or cues from the student that help predict that the behavior will occur
• What happens just before the behavior that may trigger the behavior
• Settings, situations, and other variables that influence the behavior

These observations should include the following:
• Specific days or time of day
• Specific settings such as school, home, class, hallway, or bus
• Particular subject areas such as math or P.E.
• Type or length of assignment