Attention Deficit Disorder (ADD or ADHD)

General Overview (updated 2018)

"Attention deficit is a disorder that affects children from the first months of their lives through their school years, through adolescence, and into adulthood."
Jones (1998:2)

ADD is characterised by symptoms of inattention, impulsiveness and hyperactivity to degrees that are considered inappropriate to the child's age and stage of development. ADD can generally be classified into two types, being the inattentive type or hyperactive-impulsive type. If both symptoms are present then the diagnosis is a combined type.

Below is a table from Jones (1998:3) comparing the two types of Attention deficit disorder.

ADHD Inattentive	**ADHD Hyperactive-Impulsive**
Often an easy, mellow baby	Often hard to console, colicky as baby
Tends to have lower verbal interaction	Excessive talking
Daydreamer	Physically active
Greater difficulty paying attention to the main aspects of a task	Difficulty staying on tasks and completing them
Often forgetful in daily activities	Difficulty waiting for turns
Seems unmotivated at times	Excessively impatient

OR, A COMBINATION OF BOTH

Along with the three essential features of the attention disorder, children may also exhibit difficulties with short-term memory, visual motor integration, insatiability, inconsistent performance, and social difficulties. At times a discrepancy exists between intellectual ability and actual productivity and children with ADHD often exhibit a lack of production rather than an inability to learn.
Jones (1998:3)

Developmental Areas

Children may display some of the following characteristics

Social and Emotional Development

- May become easily upset and frustrated with him/herself or others
- May exhibit inappropriate behaviours that result in negative attention from peers
- As a result of negative interactions with others, child may develop a low self esteem
- May exhibit inappropriate behaviours in order to gain attention
- May be withdrawn and go unnoticed
- May seem 'immature'
- Requires help with 'self help' tasks
- Invades the personal space of others
- May be argumentative with other children
- Acts impulsively without considering the consequences
- May attempt to leave class or group activities
- May have problems taking turns

Physical Development

- May experience difficulty with visual-motor integration
- Often experiences difficulty tuning out excessive stimuli in the immediate surroundings
- Poor motor co-ordination
- Exhibits delays in fine motor skills
- Body may appear to be in constant physical motion
- Enjoys participating in rough and tumble play. May show disregard for their own safety and safety of others.
- Crashes into walls and floors
- May also exhibit sensory integration disorder (the brain's ability to organise stimuli and recognise information coming through all the senses)

Language and Communication Development

- May require professional speech and language evaluation
- High percentage of preschool age children may exhibit speech and language problems
- Speech may lack fluency and be disorganised
- May lack ability to control or predict consequences of their words and say inappropriate things at the wrong time (Jones, 1998:29)
- Lack communicative control
- Listening skills are often poor
- Lack of attention contributes to poor listening habits (Jones, 1998:29)
- Unable to follow simple instructions
- May interrupt or talk excessively.

Cognitive Development

- Has difficulty focusing on tasks – easily distracted by sounds or visual stimuli
- Learning difficulties may result from inability to focus or pay attention
- May be unable to finish or complete a desired task in an appropriate way e.g. direct refusal to pack toys away and complete game
- May become overwhelmed or frustrated with new or challenging tasks.
- May be forgetful. Might forget instructions or be prone to losing things.

ADHD
Inclusion Strategies

Each child diagnosed with **ADHD** will be different and individual. It is important to gain information from the parents as to what characteristics of **ADHD** their child displays. It is important to work closely with the parents as well as any additional support specialists e.g. therapists who may be involved with the child. It is also important to gain an understanding from the parent as to what is the most important aspect of their child attending your service. What is it that parents hope to gain from using your service? The following inclusion strategies are just some examples which may be applied to support the inclusion process. This list is only the start and it is dependant on a variety of factors such as environment, length of time child is in care, child's interest, likes, dislikes, skills already achieved. The strategies are divided into developmental areas however some strategies overlap and assist in a variety of developmental areas.

Social and Emotional Development

- Support children's social development by recognising and positively reinforcing their successful social interactions.
- Talk with the group about appropriate social behaviours in a positive way and provide picture cues to prompt children's language e.g. sharing, listening, keeping hands and feet to themselves.
- Be consistent in your disciplinary interactions with the child.
- Focus on what the child can do and provide opportunities for the child to engage in experiences that they are really interested in. This helps to build their confidence and self esteem.
- Maintain a calm environment that promotes emotional security through consistency.
- Planned relaxation & quiet activities can assist children in maintaining a calm state.

Physical Development

- Provide opportunities for children to challenge themselves and expend excess energy.
- Provide obstacle courses and outdoor experiences such as throwing bean bags at a target. These opportunities allow children to expend energy and aggression while developing hand-eye co-ordination and motor planning skills.
- Experiences that enhance visual motor integration such as fine motor tasks including pre-writing skills may be helpful.
- Use strategies such as playing soft music or redirecting to a quiet activity when the child becomes over-active.

Language and Communication Development

- Provide a plan for the daily events/routine and discuss this with the child so they know what comes next e.g. morning greeting, outdoor play, morning tea, music, indoor play, lunch, rest.
- Provide pictorial cues to accompany the routine so that children with ADHD/ADD can anticipate what comes next. Establish a routine for transitions e.g. when indoor play is about to finish, give the children a warning by playing music for them to tidy up to.
- Ensure the child gives eye contact before giving them information. Use cues such as saying the child's name or saying 'are you ready to listen?' before giving a key instruction.
- Use clear and simple instructions, ensuring instructions have been understood before giving more. Asking them to repeat the instruction after it has been given can be a useful way to check they have heard and understood.

Cognitive Development

- Set achievable goals and tasks for the child that they are capable of achieving.
- Ensure experiences provided are within the child's capacity for maintaining attention.
- Use teaching techniques that avoid the possibility of making mistakes to build confidence and use strategies that prevent any tendency for 'switching out' behaviour.
- Remind children of routines regularly.
- Give instructions that the child is able to understand.
- Reinforce learning with concrete representation.
- Avoid tasks that frustrate the child.

Reference

The Royal Children's Hospital Melbourne (updated 2012) **ADHD – An Overview** https://www.rch.org.au/kidsinfo/fact_sheets/ADHD_an_overview/

Ledgerton, S. and Vize, A. (2010) **A Practical Guide to Supporting Children with ADHD** Teaching Solutions: Albert Park, Australia

Deiner, P.L. (1993) **Resources for Teaching Children with Diverse Abilities - Birth through Eight.** Harcourt Brace: Orlando

Umansky, W. and Hooper, S. (1998) **Young Children with Special Needs** Third Edition Prentice-Hall: New Jersey, USA

Gilbert, P.(1996) "**The A-Z Reference Book of Syndromes and inherited disorders—2nd Edition**." Stanley Thornes (Publishers) Ltd: United Kingdom

Kozma,C. & Stock, J. (1993) **Caring for every child—Ideas to meet diverse needs in Child Care**. Funded by the Commonwealth department of Human Services and Health: Sydney

Asperger's Syndrome

Defined by Hans Asperger, a Viennese paediatrician, as children with poverty of social interaction, failure of communication and the development of special interests. This definition included a consistent pattern of abilities and behaviour that predominantly occurred in boys.

The pattern behaviours include:

- Lack of empathy
- Little ability to form friendships
- One-sided conversations
- Intense absorption in a special interest
- Clumsy movements

Effects on Developmental Areas

Children may exhibit the following developmental characteristics

Social and Emotional Development

- May be confused by emotions of others
- May have difficulty in expressing own feelings
- May have limited facial expression
- May use body language to express anger or frustration but less frequently to express emotions such as embarrassment or pride
- May be unable to pick up on subtle cues of other's body language e.g. frown meaning anger

Physical Development

- May experience 'motor-clumsiness'
- May lack upper or lower limb co-ordination
- May have difficulties catching and throwing—poor co-ordination and timing
- May have impaired imbalance
- May have impaired inability to use both hands (manual dexterity)

Language and Communication Development

- May have delay in development of speech
- May have impaired ability to have a natural conversation
- May have an impaired understanding of language in the social context
- Expressive language may appear superficially perfect
- May have peculiar voice characteristics—unusual pitch, stress or rhythm
- May have impairments in comprehension, including misinterpretations of literal/implied meanings
- May have repetitive speech patterns
- May have difficulty with auditory discrimination e.g. focusing on one voice when there is noise in the background

Cognitive Development

- May have good long –term memory may have a photographic memory
- May have one track mind and rigid thinking
- May have unusual imaginative play (child may take on the role of an object in play rather than a person)

Aspergers Syndrome
Inclusion Strategies

Each child diagnosed with **Aspergers Syndrome** will be different and individual. It is important to gain information from the parents as to what characteristics of **Aspergers Syndrome** their child displays. It is important to work closely with the parents as well as any additional support specialists e.g. therapists who may be involved with the child. It is also important to gain an understanding from the parent as to what is the most important aspect of their child attending your service. What is it that parents hope to gain from using your service? The following inclusion strategies are just some examples which may be applied to support the inclusion process. This list is only the start and it is dependant on a variety of factors such as environment, length of time child is in care, child's interest, likes, dislikes and skills already achieved. The strategies are divided into developmental areas however some strategies overlap and assist in a variety of developmental areas.

Social and Emotional Development

- Be aware of the child's social and emotional impairment and plan experiences to help these skills to develop.
- Read stories about different feelings and emotions.
- Display pictures of children engaging in different activities and talk about their facial expressions and why they may be feeling that way.

- Make “happy” books with a picture of a happy face on the cover (perhaps a photo of the child looking happy if you have permission to do so) and find pictures, draw pictures etc of things that make a child feel happy to put in the scrap book.
- Sing songs about facial expressions and feelings.
- Toys such as “Mr. Potato Head” can help children explore facial expressions.
- Support developing friendships with other children.
- Model appropriate social behaviours for children.
- Talk about what is happening in the social environment and teach children how to look for social cues.
- Children may need to be taught specifically how to engage in, participate in and end social situations such as play.
- Use language sessions to talk about friendships and friendly behaviours such as co-operation and sharing.
- Provide clear explanations to children about misunderstandings or inappropriate displays of social behaviour.
- Encourage the child to be aware of what other children are doing in the room and use these cues as indicators reinforcing appropriate behaviours to the child.

Language and Communication Development

- Explain things clearly avoiding figures of speech and double meanings.
- Allow children time and opportunity to explain their ideas/thoughts….
- Sing songs and play games that encourage children to use loud and soft voices.
- Use different pitches and rhythms when singing.
- Read stories that include social interactions between characters for verbal and pictorial representation of social behaviours.

Cognitive Development

- Games such as “what’s wrong” cards can be used to encourage flexible thinking.
- Provide visual and concrete representations of cognitive tasks.
- Use concrete representations of daily events/routines to encourage awareness of what comes next.

Physical Development

- Provide opportunities for children to develop balance etc using obstacle courses.
- Use low beams or ropes for children to walk along.
- Play games that encourage throwing and catching skills e.g. bouncing balls.
- Be aware of the child’s skills and always provide appropriate and achievable challenges (caution—over challenging can cause frustration).
- Be aware of sensory sensitivity to sound, touch, pain, temperature etc.

Reference

The Autistic Children's Association of Queensland Inc 1995: General Overview of Autism
Umansky, W. and Hooper, S. (1998) ***Young Children with Special Needs*** Third Edition New Jersey, USA:Prentice-Hall

Deiner, P.L. (1993) ***Resources for Teaching Children with Diverse Abilities - Birth through Eight.*** Harcourt Brace:

Disclaimer

Autism Spectrum Disorder

Autism Spectrum Disorder can affect people of all intellectual levels with research suggesting that the majority of the affected population are males with an average two to three males to every female.

Over the last 30 years, with further research and understanding into autism spectrum disorder, it is becoming recognised that within the autistic spectrum there are a wide range of characteristics which can vary in severity in each individual.

The triad of impairments are three areas in which people with an autism spectrum disorder have difficulties with:

1. Impairments of social interaction
2. Impairments of communication
3. Impairments of imagination

People with autism spectrum disorder may also demonstrate strong sensory seeking behaviours, sensory avoidance behaviours and/or obsessive behaviours.

Many behaviours that could be associated with autism spectrum disorder are also typical of normal development. It is the combination and pattern of the behaviours, their intensity, and the fact that they persist beyond the normal age that leads to a diagnosis of autism.

A doctor makes a diagnosis of autism based on descriptions and observations of the person's development and behaviour. A diagnosis of autism spectrum disorder before the age of two is rare. Depending of where in the spectrum a child with autism falls, average diagnosis age varies from 3 to 7 years old.

Effects on Developmental Areas

Children diagnosed as having autism spectrum disorder will demonstrate characteristics that can vary enormously in each individual.

Social and Emotional

Social and Emotional Development

- Severe socialisation deficit experiencing difficulties interacting meaningfully
- Reluctant to give eye contact
- Appears to lack desire to share their activities with others - social isolation

- Sometimes it may be misinterpreted that children with autism prefer to be alone – a younger child may make many inappropriate attempts to join in, or will watch others with great interest but have no idea how to become involved. Does not know how to go about making friendships and joining peer initiated activities. (The ability for the child to be taught how to behave appropriately in social interactions is also severely reduced)
- Lack of understanding of issues from another's point of view – social empathy
- Cannot understand that other people have their own beliefs, desires and intentions which guide their behaviour
- Lack of empathy (often misconstrued as selfishness) is not wilful on the part of the person with autism rather an inability to respond in any other way
- May treat people as tools or equipment – something to use to turn on a tap, open a door, get carried by or lean on. Some people with autism may be able to respond appropriately to others within very familiar routines or to very familiar people, but become confused and anxious at any other time. At times may appear rude because of their inability to understand and use the more subtle aspects of social interaction e.g. by approaching strangers inappropriately; by ignoring another person's attempts to interact etc.
- May not differentiate between familiar and unfamiliar people
- May have difficulty in taking turns and/or sharing with peers
- May often be observed on the outside of social activities, watching, but not joining in
- May be unintentionally aggressive in an attempt to be social
- May cope very badly with being teased
- May be limited in play skills: plays with only a few toys and does not display imaginative play
- May lack self-esteem

Language and Communication Development

- Severe communication deficit involved affecting all aspects
- May not readily *understand* or *use* appropriate forms of communication including verbal language, body language, facial expression, tone of voice and gestures
- Difficulties may be very subtle and well-disguised by a more able person with autism - no communication deficit may be noticed by casual observer
- Limited or no speech and/or lack typical communicative gestures
- Difficulty in developing and understanding any other forms of communication such as gestural systems or picture-based systems
- Speech may develop to varying degrees, rarely developing to an age-appropriate level of ability
- Rarely develops ability to cope with complex or abstract concepts
- May be unable to communicate wants, express concerns or fears, or be able to answer questions reliably - also difficulties in making or expressing choices
- Individual's expressive and receptive skills may appear far better than they really are in routine situations resulting in others overestimating their ability and underestimating the severity of their communication deficit. This may impact on ability to succeed in a number of situations. May speak in complete sentences but be unable to carry on or maintain an interactive conversation and revert to non-verbal behaviours when confused or anxious

- Guide adult by the hand to a desired object rather than ask, or do things independently, or do without, rather than use a person for assistance
- Uses repetitive sounds or repeats certain questions or phrases over and over
- Unusual vocal quality (tone, pitch, speed of speaking)
- Reverse pronouns (will use “you” instead of “I”, etc.)
- Unable to consistently follow verbal directions
- Literal and concrete understanding of language

Sensory Information Processing

- May experience great difficulty processing information received from senses - usually nothing wrong with the sense organs themselves, but the information is not able to be processed normally when it gets to the brain
- Impacts on children’s intellectual, social and emotional development
- May be unusually sensitive to their surroundings and unable to screen out irrelevant stimuli
- Ability to attend and respond may vary from day to day – performance is typified by discrepancies, inconsistencies and variability
- May ignore some sounds but over react or be very sensitive to other sounds
- May play with, seek out or selectively react to certain sounds
- Eye contact may be actively avoided, fleeting or lacking in social intent
- May use peripheral vision rather than central vision (gives the appearance of not giving eye contact or looking)
- May focus intently on the small visual details of walls, furniture, objects, prints, pictures or body parts whilst not seeing the whole picture
- May show intense interest in light or shiny reflective surfaces e.g. may filter light through fingers or stare at lights or reflections in glasses, watch water going down the plughole etc.
- May explore by smelling or mouthing objects, people and surfaces
- May have eating problems that could be related to the smell, texture or flavour of food – often has strong preferences or refuses new foods
- May chew or eat things that are not food
- May have delayed or no response to obviously painful events
- May seek out vibrations or engage in repetitive movements such as rocking, bouncing, flapping arms and hands, or spinning with no apparent dizziness
- May hold or move hands or body in unusual (often rigid) postures
- May have difficulty with position of body in space, and motor planning
- May walk on tiptoes
- May have disturbed sleep pattern
- May have difficulty with toilet training

Adaptation to the Environment

- Finds it very difficult to interpret and process new information
- Prefer consistency - minor change to routine, activity or surroundings may cause stress

- Difficulty coping with change may result in different behaviours including cut-off and withdrawal, obsessively manipulating fingers, lining up objects or talking non-stop about dinosaurs. May react with aggression to either themselves or anyone else within reach which is usually very effective at keeping people at a distance, reducing the number of demands made upon them and thereby decreasing the amount of change they will have to cope with
- May show fear of strangers or new activities by avoiding or resisting contact
- May develop strong attraction to certain objects, routines and rituals and may stay involved with them for long periods or be upset if interrupted
- May show anxiety about certain events or schedules
- May become upset with changes or ask repeated questions about when events will occur
- May become very concerned about doing work perfectly; may become unwilling to attempt work that they feel cannot do perfectly
- May become very motivated to be in control of situations and may become very successful at manipulating people into allowing them this control

Cognitive

- May have learning difficulties
- May not stay long at activities due to low concentration span
- May require instructions, directions etc. to be repeated 2 or 3 times and requires some time to process before responding or acting.
- May have delays in skills of concentration, memory and ability to generalise
- May have difficulty understanding concepts of turn taking, sharing, how to enter into play situations.

Autism Spectrum Disorder
Inclusion Strategies

Each child diagnosed with **Autism Spectrum Disorder** will be different and individual. It is important to gain information from the parents as to what characteristics of **Autism Spectrum Disorder** their child displays. It is important to work closely with the parents as well as any additional support specialists e.g. therapists who may be involved with the child. It is also important to gain an understanding from the parent as to what is the most important aspect of their child attending your service. What is it that parents hope to gain from using your service? The following inclusion strategies are just some examples which may be applied to support the inclusion process. This list is only the start and it is dependant on a variety of factors such as environment, length of time child is in care, child's interests, likes, dislikes, skills already achieved. The strategies are divided into developmental areas however some strategies overlap and assist in a variety of developmental areas.

Social and Emotional Development

- Assign children set jobs or tasks to take responsibility for such as watering plants, setting up cups/bowls for morning tea etc. Keep the jobs consistent and routine to enable children to plan for these in their day.
- Play "Simon says" – where children copy the actions of the group leader/child care worker but are not excluded from the game if they make a mistake.
- Dramatise familiar stories with children using props including costumes, felt board stories etc.
- Consistency is important. If the child finds that every time they are given that direction, the same response is expected, or that every time they react in that way, the same consequence follows, they will learn the appropriate behaviour far more quickly.
- Limiting choices or alternatives can help child retain a feeling of control by being able to make a choice. The child can be offered the choice between two activities available – "Do you want to clear the blocks away with Shannon or tidy the reading corner with Blake?" Giving choices encourages the child to take some responsibility for their actions.
- Give the child clear information about what is going to be happening, and what will be expected of the child in that new situation giving the child the chance to prepare themselves for the event and to work out how to behave.
- Warnings help the child cope better with unpleasant events such as finishing an activity they are enjoying alerting that they have got 2 minutes left on the computer, or can have 10 more bounces on the trampoline, etc., allows the child to prepare for and deal with finishing more appropriately. Use First_____, Then _____ boards with visuals to help support the transition to a new activity, or from a preferred to non-preferred task or vice versa.
- Behaviour problems may increase when child is bored, confused, stressed, making repeated mistakes or when the child doesn't have other alternatives. In addition, some behaviour problems e.g. aggression can escalate in response to "negative correction procedures" that is punishment, a negative verbal response ("Don't do that"), a frown or yelling. The same inappropriate behaviour can be for different reasons at different times or places.
- Often has limited number of ways of communicating their feelings or needs, so one behaviour is used to communicate a number of messages. For example, a tantrum might, at different times/in different situations, mean "I don't want to", "I have to get out of here", "That hurts" or "I'm scared". Therefore, the response given to the child's inappropriate behaviour may need to vary according to the circumstances.
- Use visuals to help children understand routines (e.g. daily routines, toileting) and sequences (e.g. play sequences such as how to set up a train set or taking turns. Provide advance warning if routine is going to change.

Physical development

- Keep things in the same place to assist child to be able to move from one place to another. If you change the environment walk and talk this through with the child.
- Provide finger plays to encourage the use of both hands in a controlled manner as well as developing fine motor skills.
- Provide lock boxes and musical boards to promote finger and wrist movement and rotation.
- When setting up collage table provide clear defined areas for differing materials in boxes.
- Support toileting with timed toileting approach supported with visuals demonstrating the sequence of steps.

Language and Communication Development

- Consider whether it may be appropriate to use other forms of communication to support verbal communication such as signing or visuals.
- Encourage children to talk about what they are doing by asking several times throughout the day. Also, ask children to tell you what you or others are doing.
- Provide positive reinforcement during play times and encourage dramatic play.
- Provide clear directions and break into manageable steps in sequence.
- Maintain a calm approach to ensure situations are more likely to be successfully resolved. Being calm when dealing with a child when they are feeling anxious, upset or frightened is more likely to reassure the child, and settle them down more quickly.
- Confidence and assertiveness is necessary if a child is expected to comply with any direction given.
- The child's full attention is required *before* giving any instruction or information to establish specific "good listening" behaviour. Encourage the child to indicate that they are paying attention. For example, when a child hears their name, they should turn their body towards the person calling, put down what they are holding and *possibly* give eye contact.
- Simple, clear language and short sentences are necessary for children with autism, no matter how verbally able in some situations. Often they tune in and out of sentences, or are unable to understand some of our more ambiguous language. Limit interactive language to the fewest number of information-carrying words at a time. If the instruction contains a number of steps, give one step at a time, wait for the child to comply, and then give the next part. Frustration and confusion due to lack of understanding are major causes of behaviour problems.
- Use positive statements by telling the child what you do want them to do as the child may genuinely not know what else to do and the negative statement is of no help to them. Negative statements are more difficult to process, so the child may have difficulty understanding what is meant by it and the child may only

hear and focus on part of the statement and think they are being told to actually do that action, not stop it.

- One person only to give verbal information/directions at a time - if the person requires help to make the child understand or comply, the other adults can help by possibly physically patterning or prompting the child – e.g. modelling the desired behaviour in an obvious way.
- Plan for success - check to see that everything is set up as much as possible to guarantee success.
- Ask for attention when standing close by the child.
- Give directions when the child is fully attending.
- Carry out demanding activities at the time the child functions best such as first thing in the morning or after lunch.
- Organise the physical setting to aid the child as much as possible.
- If the child has been doing really well, avoid pushing him/her for more than he/she is capable of.
- Establish an expectation that explanations will be given after the direction is carried out, not before.
- Consistency is important. If the child knows that each time the same direction is given, the same response is expected, or that every time they react in that way, the same consequence follows, appropriate behaviour will be learned far more quickly.
- Know the message clearly before speaking & physically guide the child towards the correct place, using appropriate strategies to encourage the child to comply.

Cognitive

- Avoid generalisation.
- Use concrete representation to enhance concept development.
- Focus and reinforce relevant information, aspects, attributes and characteristics.
- Allow the child time to complete tasks and practice skills at own pace.
- Acknowledge level of achievement e.g. “you have placed that piece in the puzzle, well done” rather than just “Good boy”.

Reference

Drifte, C. & Vize, A. (2010) ***A Practical Guide to Supporting Children with Autistic Spectrum Disorders***. Teaching Solutions.

https://autismqld.com.au/ ***Autism Queensland*** accessed 25/01/2018

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Disclaimer

Cerebral Palsy

Cerebral palsy is caused by damage to the brain occurring before birth, during birth, or within the first few years after birth. The damage affects the brain's ability to control the muscles. There may be other disabling conditions caused by extensive damage to the brain including sensory disabilities, communication impairments, learning problems, seizures, ADHD, vision impairments, hearing impairments and intellectual impairments. Children who have cerebral palsy may experience difficulties moving and controlling the posture of their bodies.

Cerebral palsy is known as a developmental disability as it influences the way children develop. Children can be affected in varying degrees, from mild to severe. The degree of tension or resistance to movement (muscle tone) is often used to classify cerebral palsy along with the parts of the body involved.

Cerebral palsy is a non-progressive condition, but changes may occur due to variations during the child's growth and development and the effect of intercurrent illnesses. However with emerging research and understanding in brain plasticity, neonatal care and stem cell therapy, the future of possible cures and treatments is looking optimistic.

Physiotherapy and support may be required for children with cerebral palsy to ensure they are placed in positions that are most beneficial for their physical condition. Specialised and adaptive equipment is available and may be required to support the inclusion of children with cerebral palsy. Some of this equipment includes: prone leaners which enable a child with cerebral palsy to be placed in a supported standing position for doing activities such as puzzles or water play; corner chairs which enable children to sit at the correct height for joining in story times, playing with blocks etc. and posture chairs which provide appropriate support for a child to be included at a table (with a cut out) for painting, drawing and writing experiences. The child's therapist will be able to recommend the most appropriate equipment for each child.

The environment may require modification for children with cerebral palsy to ensure it is accessible by promoting greater control of their surroundings, independence and expanding the scope of learning experiences available.

Developmental Areas

Children may display some of the following characteristics

Social and Emotional Development

- May become easily frustrated when unable to complete tasks
- May have limited peer initiated social experiences
- Access to visiting friends and other people's places for social occasions may be difficult if friend's houses are not accessible

Physical Development

- May have jerky or uncontrollable movements
- Muscles and limbs may be rigid or stiff
- Movement may lack coordination or balance
- May be unable to sit independently and maintain posture
- May be unable to walk independently or stand unaided
- Hand-eye coordination may be poor resulting in difficulties in manipulating objects and throwing/catching activities
- Vision or hearing may be impaired
- May become quickly or easily tired
- Saliva control may be poor – difficulty keeping lips closed
- Limited control over facial muscles may cause a risk of choking when eating or drinking
- Some may have epilepsy as a co-existing condition

Language and Communication Development

- May experience difficulties in producing some speech sounds
- Difficulties in keeping up with a two way conversation
- May use augmentive or alternative communication devices

Cognitive Development

- May have had limited concrete experience with the environment
- May have learning disabilities or intellectual impairments due to damage to the brain

Health and Safety Issues

- Be aware of health implications that may affect participation in aspects of the program

Cerebral Palsy
Inclusion Strategies

Each child diagnosed with **Cerebral Palsy** will be different and individual. It is important to gain information from the parents as to what characteristics of **Cerebral Palsy** their child displays. It is important to work closely with the parents as well as any additional support specialists e.g. therapists who may be involved with the child. It is also important to gain an understanding from the parent as to what is the most important aspect of their child attending your service. What is it that parents hope to gain from using your service? The following inclusion strategies are just some examples which may be applied to support the inclusion process. This list is only the start and it is dependant on a variety of factors such as environment, length of time child is in care, child's interest, likes, dislikes and skills already achieved. The strategies are divided into developmental areas however some strategies overlap and assist in a variety of developmental areas.

Social and Emotional Development

- Encourage and plan for positive social experiences (small group experiences etc.).
- Allow the child ample time to complete tasks independently.
- Encourage children to ask questions and allow time for responses.
- Promote the opportunity for children to explore play materials.
- Provide musical experiences that allow for emotional expression.
- Internet chat rooms that are appropriate for children may be a social alternative.

Physical Development

- Provide an area with clear, uncluttered spaces.
- Be aware of the child's *medical* physical needs.
- Ensure the environment is safe and secure promoting easy access.
- Provide appropriate materials and equipment to support the child e.g. support chairs at the appropriate height and adjustable tables.
- Provide toys that are easy to grasp and manipulate including puzzles with large knobs or floor puzzles with large pieces - manipulation aids can be added for children who are unable to isolate finger movements or control wrist movements.
- Provide tactile or sensory experiences that the child can cope with and present these at a level appropriate to the child's development e.g. tactile balls such as urchin or koosh balls.
- Use musical instruments to stimulate sensory development.
- Plan smaller, manageable experiences for the child that may be an activity or game divided into smaller achievable tasks.
- Be aware of the child's abilities when providing obstacle courses etc. for the whole group and provide opportunities for children to explore movement in different ways.
- Watch for signs of fatigue and avoid children becoming over tired.
- Plan quiet and busy activities indoors and outdoors to include children's varying capacities for attending to different experiences.

- Meal time assistance may be required (with the advice of an occupation therapist)
- **Stabilising** toys for children can enhance function as children with cerebral palsy may experience difficulties with two handed tasks. Toys can be stabilised by clamping their bases to tables, using masking tape to secure them to the surface, using a non slip mat such as Dycem or securing with suction caps or velcro.
- **Grasping aids** can be used to make objects more manageable. Velcro can be placed around the child's hand and the object to create a bond between the hand and the object. Wrap foam or tape around items to make them easier to hold.
- **Boundaries** can be created by restricting the movement of toys e.g. using a track with edges for push and pull toys etc.
- **Switches** can be adapted to battery operated toys for children who have extremely limited hand function.

Language and Communication Development

- Encourage staff and children to become familiar with and utilise the child's communication system.
- Provide alternative forms of communication such as picture boards and use photos of resources available in the program.
- **Single message devices** can be used to allow the child to communicate during specific routines or play experiences. Single message devices store a verbal message and can be played by pushing the button.

Reference

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Developmental Delay

Developmental delay refers to the delay in one or more areas of a child's development when compared to atypical development in children. It may be a term used until a more specific diagnosis is made by a doctor until the exact nature of the delay is known. The significance of the delay can only be determined by observing the child's development over a period of time.

The different areas of development that may be delayed include:

- Gross motor development
- Fine motor development
- Speech and language development
- Cognitive development
- Social and emotional development

A transient developmental delay may be caused by or related to premature birth, physical illness, immaturity, lack of learning opportunities or prolonged hospitalisation.

A persistent developmental delay is most likely to be related to problems in understanding and learning, moving, communication, hearing or seeing. Assessments are required to determine what area or areas are affected.

Effects on Developmental Areas

Social and Emotional

- Separation anxiety may be experienced
- May require assistance with self help tasks including feeding, toileting and dressing
- May have a delay in social skill development
- May exhibit inappropriate behaviours towards other children such as touching and hugging (considered inappropriate due to timing, response, etc.)

Motor and Physical Development

- May have delays in gross or fine motor skill development
- May have low muscle tone
- May bump into things or fall down frequently
- May lack stamina and be listless or tire easily

Language and Communication Development

- May have difficulty speaking
- May not understand or use appropriate forms of communication due difficulty
- May have difficulty in making or expressing choices

Cognitive

- May have learning difficulties
- May have difficulty in understanding verbal directions
- May be easily distracted by noise and visual stimuli
- May have difficulty understanding concepts of turn taking, sharing, how to enter into play situations etc.

Sensory development

- May lack sensory integration
- May be tactile intolerant

Development Delay
Inclusion Strategies

Each child diagnosed with **Developmental Delay** will be different and individual. It is important to gain information from the parents as to what characteristics of Developmental Delay their child displays. It is important to work closely with the parents as well as any additional support specialists e.g. therapists who may be involved with the child. It is also important to gain an understanding from the parent as to what is the most important aspect of their child attending your service. What is it that parents hope to gain from using your service? The following inclusion strategies are just some examples which may be applied to support the inclusion process. This list is only the start and it is dependant on a variety of factors such as environment, length of time child is in care, child's interest, likes, dislikes and skills already achieved. The strategies are divided into developmental areas however some strategies overlap and assist in a variety of developmental areas. Encourage staff to ask parents about the strategies they use.

Social development

- Use strategies to assist children separating from parent e.g. set a routine in saying goodbye, finding a book to read.
- Value and acknowledge child's efforts.
- Let other children know what child is doing to reinforce the concept of him being part of the group. Do this with all children e.g. "Look Jack is doing a puzzle as well"

Physical development

- Plan physical activities for times when child is most energetic.
- Provide simple obstacle courses that the child is capable of completing to experience success.
- Provide finger plays to encourage the use of both hands in a controlled manner as well as developing fine motor skills.
- Plan for fine motor developmental tasks with adaptive equipment such as a non slip mat under the drawing paper, thick crayons or thick handled paint brushes that are easy to grasp.

Language

- Utilise the use of large clear pictures to reinforce what you are saying.
- Para-phrase back what the child has said.
- Clarify types of communication methods the child may use e.g. Makaton.
- Label areas in the room with words and pictures.
- Use sequencing cards to support children's learning of how to predict what comes next and associate events.
- Provide puppets/pictures as an extra prop when using finger plays and songs.
- Reduce the amount of instructions in one statement to allow time for the child to gain an understanding of what is been said e.g. "Hold the puppet up high" rather than "hold the puppet up high and wave it around so that all the children can see it". Once child understands to "hold the puppet up high" you can then add "Good, now all the children can see it".
- Ascertain from parents words that are familiar with the child e.g. family words that represent aspects of child life, and use these in your program.

Cognitive

- Encourage use of a bright, easily recognisable bag for the child to be able to recognise his hook/locker.
- Plan experiences that are relevant to the child's world.
- Gain information from parents about child's likes, interests and dislikes and incorporate these in your program.
- Break tasks down to smaller steps e.g. placing one puzzle piece in a time rather than expecting the puzzle to be completed.
- Allow the child time to complete tasks and practice skills at own pace.
- Acknowledge level of achievement e.g. "You have placed that piece in the puzzle, well done." rather than just "Good boy".

Reference

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Down Syndrome

Down Syndrome is a condition caused by extra genetic material located at the 21st chromosome. It is one of the most common congenital syndromes and the largest single known cause of intellectual impairment. According to Smith (1997) there is no association between Down syndrome and any given culture, ethnic group, socio-economic status or geographical region. The causes of Down syndrome are unknown; however increased maternal age is thought to increase the risk of having a child with Down syndrome.
Varying degrees of intellectual impairment may result from Down syndrome. This may affect attention, memory, abstract thinking and problem solving and generalisation skills.
According to Kozma and Stock (1993), abstract thinking - the ability to grasp concepts, or processes that can not be directly experienced through the senses - and generalisation - the ability to apply what has been learned to new situations - are areas that present the greatest learning difficulties.

Besides affecting intellectual and cognitive skills, Down syndrome may also cause one or more of the following physical characteristics: a rounded face with a flat profile due to flattened bridge of the nose and small nose size; slightly upward slanting eyes and epicanthus (a small fold of skin that runs vertically between the inner corner of the eye and the bridge of the nose); small, low set ears; slightly smaller mouth cavity and larger tongue; broad hands and feet with short digits with a single crease across the palm or sole; short stature with arms and legs short in comparison to trunk size; low muscle tone; joint laxity and diminished proprioceptive sense (movement awareness).
There are also some medical concerns related to Down syndrome including congenital heart problems and gastro-intestinal blockages, however these medical concerns will not affect all people who have Down syndrome.

In early childhood, problems may develop affecting the eyes, ears and teeth of children with Down syndrome. Eye problems may affect vision. Ear problems may result in hearing loss. Intermittent or persistent hearing loss can also affect language acquisition.
Children with Down syndrome may experience sensory processing, particularly the receiving of sensory information (Umansky and Hooper 1998). Tactile discrimination and upper and lower body awareness may also be reduced. Gross motor, fine motor and oral motor skills and cognitive development may be affected as a result of sensory processing problems.

Effects on Developmental Areas

Social and Emotional Development

- Short term delays in developing clear smiles and eye contact
- Social and emotional progress in the first year of life is essentially normal
- Shows interest in people, socially responsive and sensitive
- Pattern of good social and emotional development and good non-verbal communication skill usually continues in later years

Physical Development

There are delays in both fine motor and gross motor skills in children with Down syndrome. The physical characteristics which delay motor development include:

- *Hypotonia* or *low muscle tone* may delay development of head and body control
- *Ligament and joint laxity* refers to the looseness of the ligaments supporting the joints. Children may be unable to control excessive joint movement, nor prevent it from happening
- *Shorter limbs* in relation to their torso may be evident
- *Hand characteristics* display some unique physical appearances including two palm creases instead of three, smaller hands and fingers, undeveloped wrist bones at birth and an inward curved or slightly bent fifth finger

Language and Communication Development

- Communication skills affected by both physical and developmental delays
- Limited tongue control may result in some speech delays
- Increased tongue and jaw strength enhances the ability to control the tongue
- Children may receive speech therapy to remedy problems with articulation
- Delays in speech production may prevent children from saying clear words even though they know what they want to say
- Language progresses naturally from two word utterances to three and four word utterances or longer
- May string words together in a way that enables them to be understood but the words may lack correct grammatical understanding
- Children with Down syndrome may experience frustrations in making themselves understood. Many children may try/use gestures in order to communicate their want or needs

Health and Safety

- May experience hearing loss in the early years; as many as four out of five
- Most hearing loss will be fluctuating and caused by middle ear infections blocking the ear
- Significant minority have sensory-neural deafness which will be permanent

Cognitive

- May need help to practice and consolidate new knowledge and skills
- Some sensory processing difficulties - particularly the receiving and interpreting of sensory information
- Smaller short-term auditory memory causing delays in learning the grammatical and syntactical rules of language as memory store is used to hold spoken language for just long enough to process it for meaning

Down Syndrome
Inclusion Strategies

Each child diagnosed with **Down syndrome** will be different and individual. It is important to gain information from the parents as to what characteristics of **Down syndrome** their child displays. It is important to work closely with the parents as well as any additional support specialists e.g. therapists who may be involved with the child. It is also important to gain an understanding from the parent as to what is the most important aspect of their child attending your service. What is it that parents hope to gain from using your service? The following inclusion strategies are just some examples which may be applied to support the inclusion process. This list is only the start and it is dependant on a variety of factors such as environment, length of time child is in care, child's interest, likes, dislikes and skills already achieved. Strategies developed should be age appropriate for the child. The strategies are divided into developmental areas however some strategies overlap and assist in a variety of developmental areas.

Social and Emotional Development

- Always encourage inclusion in group activities in an active or passive role.
- Provide ample opportunity for dramatic play episodes.
- Plan for the dramatisation of favourite stories using props and felt pieces encouraging children to participate in the retelling on these stories.
- Support peer relationships support by acknowledging all in the group.
- Through play experiences, children with Down Syndrome are drawn into naturally spontaneous conversations from which their social skill development benefits enormously.

Physical Development

- Promote body stability in children e.g. providing push toys for the younger child and balance beams, jumping rope for the school age child.
- Hands can be strengthened through shovelling experiences in the sand/mud pit.
- Hammering experiences help children develop accuracy in their arm movements.
- Pouring activities in water play promote stability and control.
- Ball skills including bouncing, catching and throwing promote stability and planning for arm and hand movements. Begin with rolling experiences and substitute a ball with a balloon (to allow for slower movements) or bean bag (may be easier to catch).
- Waving streamers or ribbons through the air promotes shoulder strength.
- Obstacle courses encourage skills which enhance strength and co-ordination.
- Clapping games and finger plays promote bilateral co-ordination i.e. the ability to use both hands together, as does holding a book with one hand and turning pages with the other and lacing and threading experiences.
- Sensory experiences including play dough, finger painting etc. strengthens hands.
- Stickle bricks can be used to develop pulling apart and putting together skills
- Tactile experiences can promote sensory discrimination.

- Shape sorters, stacking rings, stacking cups, simple shape puzzles and activity boards all promote dexterity including the skills of grasp and release, pinch and thumb control, wrist movement and finger co-ordination.

Cognitive Development

- Provide experiences that allow for practice in memory, problem solving and gaining new knowledge e.g. memory games, books that ask "where is ___", "how many____", or ask child for ideas on how to problem solve e.g. "where did we put the ___ yesterday".
- Provide reminders of sensory information through activities e.g. listening to tape/CD on sounds and asking what the sound reminds you of.
- Practice lots of facial games to strengthen muscles e.g. bubble blowing, making funny faces, looking in the mirror, expressing feelings through the face - show me your sad, happy face etc..

Language and Communication Development

- Encourage the child who has Down syndrome to participate verbally themselves and avoid talking for them or allowing others to do so.
- Be alert to the child's attempts to communicate and ensure that the environment provides opportunities and time for children to practice and improve these skills.
- Respect and understand the communication systems that the child uses including sign and symbol substitutions to augment verbal communication skills.
- Child's communication skills may not necessarily reflect their comprehension i.e. the child's level of comprehension is often much higher than the level of expressive language.
- Give clear instructions and send clear messages – one at a time.
- Use consistency terms for routines e.g. do not interchange little lunch and morning tea – use one or the other.
- Provide children with advance warning and prepare them for major changes to the daily routine.

Reference

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Disclaimer

Dyslexia

Definition of Dyslexia

Dyslexia is a specific learning difficulty which is characterised by difficulties with accurate and/or fluent word recognition, poor spelling and decoding abilities. It's a syndrome of many varied reading and non reading symptoms. Dyslexia is a neurological condition, so children are born with the condition, however problems only become apparent when the child begins to use language and starts to read and write.

There is no cure for dyslexia; however appropriate intervention can have a positive impact.

Effects on Developmental Areas

Social and Emotional

- May feel unable to do the same things as other children
- Low self esteem
- May have a delay in social skill development
- May be easily distracted and have poor concentration

Motor and Physical Development

- May have delays in gross or fine motor skill development e.g. development of scissor skills or puzzles and physical activities such as climbing, running or simply bring able to stand on one foot.

Language and Communication Development

- May have delayed speech
- May have problems with pronunciation
- May have difficulty with rhyming words and learning rhymes

Cognitive

- May have difficulty in understanding verbal directions
- May have difficulty in classification and sequencing
- May have difficulty learning shapes, colours and how to write their own name
- May have poor short term memory or self-organisational skills
- May have inconsistent development. For example, they may be highly skilled in some areas of development but have surprising difficulty in other areas.

Dyslexia
Inclusion Strategies

Firstly it is important that if parents are concerned that their child has dyslexia, a diagnosis is made. Each child diagnosed with **Dyslexia** will be different and individual. It is important to gain information from the parents as to what characteristics of **Dyslexia** their child displays. It is important to work closely with the parents as well as any additional support specialists e.g. therapists who may be involved with the child. It is also important to gain an understanding from the parent as to what is the most important aspect of their child attending your service. What is it that parents hope to gain from using your service? The following inclusion strategies are just some examples which may be applied to support the inclusion process. This list is only the start and it is dependant on a variety of factors such as environment, length of time child is in care, child's interest, likes, dislikes and skills already achieved. The strategies are divided into developmental areas however some strategies overlap and assist in a variety of developmental areas. Encourage staff to ask parents about the strategies they use.

Social Development

- Ensure a positive, 'can do' ethos is promoted in your setting. Use strategies such as building on strengths, breaking challenges into small achievable steps and encouraging positive self talk (e.g. "I can do it", "If I try hard I can get there."
- Create a supportive environment where children know it is ok to ask for help without being embarrassed.
- Use activities that require sharing, turn taking and small groups, allowing the child to participate at own level.
- Value and acknowledge child's efforts.
- Provide activities that require two children to work together.
- Ensure emphasis is placed on the child's strengths and positive characteristics.

Physical Development

- Plan gross motor and fine motor activities in areas of child's interests e.g. art, home corner.
- Provide activities that require some problem solving in order for the child to achieve e.g. memory games, how many things are the same games.
- Provide finger plays to encourage the use of both hands in a controlled manner as well as developing fine motor skills.
- Plan for fine motor developmental tasks with adaptive equipment such as a non slip mat under the drawing paper, thick crayons or thick-handled paint brushes that are easy to grasp.

Language

- Utilise the use of large clear pictures to reinforce what you are saying.
- Para-phrase back what the child has said.
- Label areas in the room with words and pictures.
- Use sequencing cards to support children's learning of how to predict what comes next and associate events.
- Provide puppets/pictures as an extra prop when using finger plays and songs.
- Reduce the amount of instructions in one statement to allow time for the child to gain an understanding of what is been said e.g. "Hold the puppet up high" rather than "hold the puppet up high and wave it around so that all the children can see it." Once child understands to "hold the puppet up high" you can then add "Good, now all the children can see it".
- Speak slowly and ensure the child is sitting directly in front of the teacher during group sessions.
- Ascertain from parents words that are familiar with the child e.g. family words that represent aspects of child life and use these in your program.

Cognitive

- Have a clear structure and routine to the day.
- Encourage use of a bright easily recognisable bag for child to be able to recognise his hook/locker.
- Plan experiences that are relevant to the child's world.
- Gain information from parents about child's likes, interests and dislikes and incorporate these in your program.
- Break tasks down to smaller steps e.g. placing one puzzle piece in at a time rather than expecting the puzzle to be completed.
- Allow the child time to complete tasks and practice skills at own pace.
- Acknowledge level of achievement e.g. "you have placed that piece in the puzzle, well done" rather than just "Good boy".

Reference

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Epilepsy

Epilepsy is a disorder of the brain which takes the form of recurring seizures. These occur as a result of a brief disturbance in the brain's electrochemical activity. Sudden bursts of this electrochemical activity scramble the brain's messages upsetting the brain's normal control of the body.

Seizures can sometimes look frightening but rarely cause any damage to the brain. Once the seizure is over, the person gradually returns to a normal state without any ill-effects.

Epilepsy is a common condition in our community. Research suggests that 2-3% of the Australian population will develop the condition at some stage in their lives.

Most people have their first seizure before the age of 20. The next most vulnerable group is the elderly. However epilepsy can develop at any age.

Many factors can contribute to the development of epilepsy including brain infections, head injuries, cerebral tumours and strokes. It is also now recognised that some types of epilepsy may be inherited.

While advances in modern medical and scientific technology have made it easier to pinpoint those factors which may contribute to the development of epilepsy, in 50% of cases it is not always clear why the condition develops.

Recognising seizures

- There are many different types of seizures. Seizures that occur in just one part of the brain are called **partial seizures**. Seizures that affect the whole brain are called **generalised seizures**. It is not uncommon for people with epilepsy to experience more than one seizure type.
- The effect that a seizure has on a person depends on which part of the brain is involved. The effects may include:

  - An altered state of consciousness
  - Uncontrolled body movements
  - Alterations in sensation, perception, emotion and/or autonomic functions (e.g. pulse rate) or all of these in various combinations.

Four common types of seizures are:-

- Tonic-clonic
- Absence
- Simple partial
- Complex partial

Tonic clonic seizures
(Previously known as grand mal)

- This type of seizure involves the whole brain i.e. it is a generalised seizure.
- It is the seizure type which most people think of when they think of epilepsy.
- With a tonic-clonic seizure a person's body goes stiff all over and they fall to the ground unconscious (this is called the tonic phase). After a short time they start strong, rhythmic shaking movements (this is called the clonic phase). They may dribble from the mouth, go blue or red in the face, or lose control of their bladder or bowel.
- They may however vomit or bite their tongue and can sometimes injure themselves if they hit nearby objects as they fall or convulse.
- The seizure normally stops after a minute or two. At this time the person is usually confused and drowsy. They may have a headache and want to sleep. This drowsiness can last for a number of hours.

Absence seizures
(Previously known as petit mal)
Childhood absence epilepsy - also called 'petit mal' epilepsy. Onset age is usually three to 10 years. It involves brief staring spells and is often outgrown.

- This is another type of seizure involving the whole brain.
- It is more common in children.
- With this type of seizure, the person loses awareness of what is happening around them but they rarely fall to the ground. They simply stare and their eyes might roll back or their eyelids flutter.
- In addition, low self-esteem can result from overprotection, lack of discipline or the child feeling different to other children.
- It can sometimes be difficult to tell the difference between absence seizures and daydreaming. Absence seizures begin suddenly, last a few seconds and then stop suddenly allowing and the person to carry on with what they were doing.
- Although these seizures last only a few seconds, they can occur several times daily, and thus be very disruptive to learning.

Simple partial seizures

- This type of seizure involves only one part of the brain. The symptoms the person experiences will depend on which part of the brain is involved. They remain fully conscious throughout the seizure.
- The seizure may involve movements-like stiffness or shaking or an abnormal feeling in one part of the body such as numbness or an unpleasant smell or taste. This usually lasts for less than a minute and then the person recovers.

Complex partial seizures

- This type of seizure affects only one part of the brain but the person's conscious state is altered. They often appear confused and dazed and may do strange things like fiddle with their clothes, make chewing movements with their lips or make unusual sounds.
- The seizure usually only lasts for one to two minutes but the person may be confused and drowsy for some minutes to several hours afterwards.

Effects on Developmental Areas

Children may exhibit the following developmental characteristics

Social and Emotional Development

- Reduced self esteem
- Reluctance to participate in social activities
- May have difficulty making friends
- May appear to have little or no empathy for others

Physical Development

- Seizures (to varying degrees)

Cognitive Development

- Intellectual impairment
- Limited skills in comprehension

Language Development

- Social language deficit due to limited social experiences
- Delayed language development due to seizures

Epilepsy
Inclusion Strategies

Each child diagnosed with **Epilepsy** will be different and individual. It is important to gain information from the parents as to what characteristics of **Epilepsy** their child displays. It is important to work closely with the parents as well as any additional support specialists e.g. therapists who may be involved with the child. It is also important to gain an understanding from the parent as to what is the most important aspect of their child attending your service. What is it that parents hope to gain from using your service? The following inclusion strategies are just some examples which may be applied to support the inclusion process. This list is only the start and it is dependant on a variety of factors such as environment, length of time child is in care, child's interest, likes, dislikes and skills already achieved. The strategies are divided into developmental areas however some strategies overlap and assist in a variety of developmental areas.

Social and Emotional Development

- Provide an environment that is responsive to child's social and emotional needs.
- Be aware of stress or fear that may trigger seizures.
- Provide small group social activities to support development.

Physical Development

- Be aware of fatigue as a trigger for seizures.
- Over-excitement may also trigger seizures.
- Check the physical environment that may trigger seizures e.g. flicking lights, streamers etc. dangling from the ceiling.
- Obtain correct procedure for managing a seizure and first aid ensuring all staff are appropriately trained.
- Ensure policies and procedures for managing medical conditions are in place.

Cognitive Development

- Plan and provide cognitive tasks for children as they would be provided for all children in the group.
- Be aware of any other conditions that the child may have such as intellectual impairment and modify your program accordingly.

Language Development/Communication

- Talking about epilepsy can help children begin to ask questions and reduce some of the myths and fantasies surrounding the condition.
- Provide interesting and stimulating activities for all children that enhance language development.
- Use visual strategies for supporting language development (pictures etc) in addition to verbal cues and stories.

Reference:

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www.eqi.org.au Epilepsy Queensland Inc

www.betterhealth.vic.gov.au

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Foetal Alcohol Syndrome

Foetal alcohol syndrome is a combination of mental and physical birth defects that can result in intellectual disability, growth deficiencies, central nervous system dysfunction, cranio-facial abnormalities and behaviour disorders. Foetal alcohol effect is a less severe set of the same symptoms. FAS/FAE produces irreversible physical, mental and emotional effects.

Foetal alcohol syndrome is the result of heavy alcohol use—about six standard drinks per day during pregnancy. Pregnant women who drink less than this may have a child with the condition known as foetal alcohol effects.

Developmentally, children who have FAS/FAE may function within the range of 'typical' development, except they may manifest disorders such as learning disabilities, communication disorders, hyperactivity and attention/concentration disorders.

While FAE is probably far more prevalent than FAS, it is more difficult to isolate and attribute to alcohol consumption. FAS can be diagnosed at any time during a child's development.

Effects on Developmental Areas

Social and Emotional Development

- May not demonstrate 'stranger anxiety' as an infant
- May appear social but uses inappropriate physical proximity
- May have the inability to adapt to change and environment
- May be impulsive
- May have poor comprehension of social rules and expectations
- May have difficulties in establishing friendships

Physical Development

- May small for age as a baby
- May have weak suckling reflex and weak muscle tone
- May have feeding difficulties
- May have slow motor development
- May be short and 'elf like' in manner and appearance
- May later become hyperactive and easily distracted
- May have hearing impairment
- May be susceptible to infections of all kinds especially those associated with the respiratory tract

Cognitive Development

- May have deficits in memory retention.
- May have difficulty differentiating fact from fantasy.
- May have difficulty in predicting consequences of own behaviour
- May have delays in intellectual development
- May have learning disabilities and delays in learning beyond the normal aspects of the development process

Language Development /Communication

- May have slow acquisition of language skills (in terms of milestones)
- May have difficulties in understanding and following instructions

Foetal Alcohol Syndrome
Inclusion Strategies

Each child diagnosed with Foetal Alcohol Syndrome will be different and individual. It is important to gain information from the parents as to what characteristics of Foetal Alcohol Syndrome their child displays. It is important to work closely with the parents as well as any additional support specialists e.g. therapists who may be involved with the child. It is also important to gain an understanding from the parent as to what is the most important aspect of their child attending your service. What is it that parents hope to gain from using your service? The following inclusion strategies are just some examples which may be applied to support the inclusion process. This list is only the start and it is dependant on a variety of factors such as environment, length of time child is in care, child's interest, likes, dislikes and skills already achieved. The strategies are divided into developmental areas however some strategies overlap and assist in a variety of developmental areas. Encourage staff to ask parents about the strategies they use.

Social and Emotional Development

- Foster independence in self help tasks and play as a long term goal for the child.
- Model appropriate strategies for social behaviour (small group experiences can foster social skill development in a less threatening situation).
- Encourage and promote decision making e.g. would you like to do a painting or play in home corner.
- Provide advanced warning for change in routines and events.
- Provide a consistent daily routine.

Physical Development

- Be aware of delays in physical development and motor skills and provide physical activities that are achievable e.g. lower the balance beam, roll the ball rather than throwing.
- Encourage the routine of asking for assistance to develop the skill of working with others and identifying when a task is too hard.
- Provide small challenges that are achievable. Base those challenges on areas of the child's interests and likes.
- Regularly review the layout of the environment to identify any aspects that contribute to distractions e.g. is music too loud and always on, is there too much going on at one time in the room.

Cognitive Development

- Provide concrete examples to assist in learning. Use pictures, sensory resources to assist in the understanding e.g. puppets, felt boards, pictures.
- Provide small group experiences e.g. two or three children in a small activities area. These activities can also be set up to require co-operative play thus supporting the social development.
- Be aware of learning disabilities and prepare experiences that promote learning e.g. use visual strategies.
- Encourage decision making skills and program ownership with the child by offering them choices about their learning and limit those choices to two at any given time.
- Provide concrete representation of the daily routine to assist children understand what is expected of them and can prepare for what is happening in the day e.g. picking up toys should be done with an adult to model expectations, use a sequence of photos to outline a routine such as the process required to prepare for morning tea.

Language Development/Communication

- Speak clearly and give one instruction or direction at a time.
- Ensure child understands before providing more verbal information or giving another direction.
- Provide opportunities for repetition and simple verbal instructions e.g. repeat what you are saying.
- Use other forms of communication to enhance understanding for the child e.g. pictorial/photographic.
- Add descriptive words to increase child's vocabulary and understanding.

Reference

Aspen Reference Group Caregiver Education Guide for Children with Developmental Disabilities. Aspen Publication 1997 ISBN 0834210347

Branelly Kylie Ideas for inclusion & Programming Tips. Book 1. CARATA 2000. ISBN 187 674 304 2

Streissguth A “Foetal Alcohol Syndrome” Paul Brookes Publishing 1998

Gilbert P“ The A-Z Reference Book of Syndromes & Inherited Disorders” Stanley Thornes Publishers Ltd 1996

Global Development Delay

Global developmental delay is defined as significant delay in two or more developmental domains. A child may have global developmental delay owing to conditions such as cerebral palsy, neuromuscular disorders and/or early environmental deprivation. Children with global developmental delay will not necessarily have intellectual impairment. Early diagnosis does improve outcomes. The different areas of development that may be delayed include:

- Motor skills (Gross and Fine) – e.g. rolling, sitting up, walking or picking up smack objects
- Speech and language development – e.g. identifying sound, imitating speech sounds, babbling
- Cognitive development – the ability to learn new things or to reason
- Social and emotional development – making friends, sharing, turn-taking
- Daily activities – e.g. eating, dressing

Rett Syndrome is the leading diagnosable cause of global developmental delay while fragile X is the most common inherited disorder.
Ongoing tests for a child with global developmental delay assists in identifying the cause.

Effects on Developmental Areas

Social and Emotional

- May require assistance with self help tasks including feeding, toileting and dressing
- May have a delay in social skill development
- May exhibit inappropriate behaviours towards other children such as touching and hugging (considered inappropriate due to timing, response, etc.)

Motor and Physical Development

- May have delays in gross or fine motor skill development
- May have low muscle tone
- May bump into things or fall down frequently
- May lack stamina and be listless or tire easily
- May have vision and hearing difficulties
- May have seizures

Language and Communication Development

- May have difficulty speaking
- May not understand or use appropriate forms of communication
- May have difficulty in making or expressing choices

Cognitive

- May have learning difficulties
- May have difficulty in understanding verbal directions
- May be easily distracted by noise and visual stimuli
- May have difficulty understanding concepts of turn taking, sharing, how to enter into play situations

Global Development Delay
Inclusion Strategies

Each child diagnosed with **Global Developmental Delay** will be different and individual. It is important to gain information from the parents as to what characteristics of **Global Developmental Delay** their child displays. It is important to work closely with the parents as well as any additional support specialists e.g. therapists who may be involved with the child. It is also important to gain an understanding from the parent as to what is the most important aspect of their child attending your service. What is it that parents hope to gain from using your service? The following inclusion strategies are just some examples which may be applied to support the inclusion process. This list is only the start and it is dependant on a variety of factors such as environment, length of time child is in care, child's interest, likes, dislikes and skills already achieved. The strategies are divided into developmental areas however some strategies overlap and assist in a variety of developmental areas. Encourage staff to ask parents about the strategies they use.

Social development

- Use strategies to assist children separating from parent e.g. set a routine in saying goodbye, finding a book to read.
- Value and acknowledge child's efforts.
- Let other children know what child is doing to reinforce the concept of him being part of the group. Do this with all children e.g. "Look Jack is doing a puzzle as well".

Physical development

- Provide simple obstacle courses that the child is capable of completing to experience success.
- Provide finger plays to encourage the use of both hands in a controlled manner as well as developing fine motor skills.
- Plan for fine motor developmental tasks with adaptive equipment such as a non slip mat under the drawing paper, thick crayons, thick-handled paint brushes that are easy to grasp.

Language

- Utilise the use of large clear pictures to reinforce what you are saying.
- Para-phrase back what the child has said.
- Clarify types of communication methods the child may use e.g. Makaton.
- Label areas in the room with words and pictures.
- Use sequencing cards to support children's learning of how to predict what comes next and associate events.
- Provide puppets/pictures as an extra prop when using finger plays and songs.
- Reduce the amount of instructions in one statement to allow time for the child to gain an understanding of what is been said e.g. "Hold the puppet up high" rather than "hold the puppet up high and wave it around so that all the children can see it." Once child understands to "hold the puppet up high" you can then add "Good, now all the children can see it".
- Ascertain from parents words that are familiar with the child e.g. family words that represent aspects of child life and use these in your program.

Cognitive

- Encourage use of a bright easily recognisable bag for child to be able to recognise his hook/locker.
- Plan experiences that are relevant to the child's world.
- Gain information from parents about child's likes, interests and dislike and incorporate these in your program.
- Break tasks down to smaller steps e.g. placing one puzzle piece in a time rather than expecting the puzzle to be completed.
- Allow the child time to complete tasks and practice skills at own pace.
- Acknowledge level of achievement e.g. "you have placed that piece in the puzzle, well done" rather than just "Good boy".

Reference

www.aan.com/practice/guideline
www.rch.org.au

Insecure Attachment and Attachment Disorders

Attachment Disorder (AD) covers a range of behaviour problems that are common in children who did not receive sufficient care during the first two years of life. Deprivation, neglect or abuse may be the major element of cause during early childhood however this can not be a certainty before the age of 7 years. Thus, it would be wrong to assume that a child under the age of 7 years, who has had severe trauma in the early years through poor care, would be diagnosed as having Attachment Disorder. Many professionals hesitate to use such a severe diagnosis early in life due to the far too radical therapy methods used such as the "holding therapy".

By definition, Attachment Disorder is the inability to form normal relationships with others with an enormous delay in social development.

Insecure attachments influence the developing brain. Interactions with others, self-esteem, self-control, learning, and optimum mental and physical health are affected. Symptoms of insecure attachment may be similar to common developmental and mental problems including ADHD, Autism Spectrum Disorder, Depression, and Anxiety Disorders.

The developmental age needs to be considered as with any characteristics of development ability. E.g. enuresis (bedwetting) is a normal symptom in a two year old but not a 12 year old.

Many strategies for Attachment Disorder include those that belong to trauma therapy, cognitive-behavioural therapy, reality therapy etc. and should be left to the professional who has knowledge and skills in this area. It is not the role of the childcare worker to undertake these. Attachment therapy is an interactive process of assisting the child to develop positive emotional connections with peers and adults alike.

Understanding the purpose of the behaviour the child uses is integral, thus, understanding and empathy are important tools that the parent and therapist must use.

Before being able to assist a child to move towards a secure model of attachment, consideration of the nature of the child's current pattern of attachment relationships needs to be taken.

Effects on Developmental Areas

Social and Emotional Development

- May have severe socialisation deficit, experiencing difficulties interacting meaningfully
- May be reluctant to give eye contact
- May make many inappropriate attempts to join in, or will watch others with great interest but have no idea how to become involved. Does not know how to go about making friendships and joining peer initiated activities
- May have lack of understanding of issues from another's point of view – social empathy
- May not understand that other people have their own beliefs, desires and intentions which guide their behaviour
- May display intense anger, rages and aggressive or bullying to other children
- At times, may appear rude because of their inability to understand and use the more subtle aspects of social interaction e.g. by approaching strangers inappropriately; by ignoring another person's attempts to interact
- May not differentiate between familiar and unfamiliar people
- May have difficulty in taking turns and/or sharing with peers
- May often be observed on the outside of social activities, watching, but not joining in.
- May be unintentionally aggressive in an attempt to be social
- May be limited in play skills: plays with only a few toys and does not display imaginative play
- May lack self-esteem
- May be impulsive
- May be demanding or clinging

Physical Development

- May exhibit poor hygiene practices
- May have chronic body tension
- May be clumsy and accident prone with high pain tolerance
- May exhibit "hypervigilance' (chronic state of being on guard)
- May be destructive to self, property or others
- May have abnormal eating habits
- May have sleep disturbances
- May display wetting or soiling and may wet/soil on furniture or objects
- May display inappropriate sexual behaviour

Language and Communication Development

- May not readily *understand* or *use* appropriate forms of communication including verbal language, body language, facial expression, tone of voice and gestures
- May have limited or no speech and/or lack typical communicative gestures
- May not be able to develop the ability to cope with complex or abstract concepts
- May be unable to communicate wants, express concerns or fears, or be able to answer questions reliably
- May chatter persistently or ask nonsense questions
- May be superficially engaging and charming

Cognitive

- May have learning difficulties
- May not stay long at activities due to low concentration span
- May require instructions, directions etc. to be repeated 2 or 3 times and require some time to process before responding or acting.
- May have delays in skills of concentration, memory and ability to generalise
- May have difficulty understanding concepts of turn taking, sharing, how to enter into play situations.
- May have difficulty coping with change which may result in different behaviours
- May react with aggression to either themselves or anyone else within reach
- May become upset with changes or ask repeated questions about when events will occur

Attachment Disorder
Inclusion Strategies

Each child diagnosed with **Attachment Disorder** will be different and individual. Each child may have several, but not all, of the characteristics. The symptoms may be overt or covert. It is important to gain as much information from the parents/guardians as to what characteristics of **Attachment Disorder** the child displays. It is important to work closely with the parents/guardians as well as any additional support specialists e.g. therapists who may be involved with the child. It is also important to gain an understanding from the parent/guardian as to what is the most important aspect of the child attending your service. The following inclusion strategies are just some examples which may be applied to support the inclusion process. This list is only the start and it is dependant on a variety of factors such as environment, length of time child is in care, child's interest, likes, dislikes, skills already achieved. The strategies are divided into developmental areas however some strategies overlap and assist in a variety of developmental areas.

Social and Emotional Development

- Play games that help children to understand and recognise emotions such as watching people, DVD without the sound on.
- Provide important specific tasks to the child to give them a sense of responsibility, ownership and being a vital member of the group
- Model positive and appropriate social skills to the child. Utilise activities that help the acquisition of social skills.

Physical Development

- Calming activities need to be included during the day to assist the child in learning how to self regulate.
- Touch including cuddles and hugs are an important human need and should be included within the routines of the day. A hand on a shoulder, finger or arm wrestling is often less threatening than tight hugging or kissing.

Language and Communication Development

- Open two way communication between parents /carers and staff is the foundation of a shared care approach to child care.
- Be consistent in your response. E.g. if the child has timeout for not following through on a task then timeout should be given every time.
- Maintain a calm controlled stance despite the child's behaviour while acknowledging the child's behaviour without engaging in the argument.
- Respect for adults and authority needs to be modelled and taught.
- Provide varying activities which include communication; both verbal and non verbal.

Cognitive

- Patience must be shown as the child learns new coping strategies and behaviours.
- Structure and routine are integral to support the child. Avoid changing the structure or routine.
- If changes need to occur give the child as much advanced notice as possible and keep reminding the child about the changes. Walk and talk through the changes that will occur.
- Provide problem solving activities with the whole group including the child.
- Use charts, calendars and daily planners to help the child develop organisational skills. This will assist the child to complete a task thus increasing the motivation to try new things with success.

References:

Rolfe, Sharne — "Rethinking Attachment for Early Childhood Practice" Allen & Unwin 2004

Harrison Linda — "Attachment – building secure relationships in early childhood" ECA 2003.

Cain, C.S. — "Attachment disorders – Treatment strategies for traumatized children" Jason Aronson Publishing 2006

Rygaard N.P. — "Severe attachment disorder in childhood" Springer Wien New York 2006

Intellectual Disability

A child with an intellectual disability often demonstrates intellectual functioning (e.g. learning, reasoning, problem solving) that is significantly below average. In addition to this, intellectual disability also affects that child's adaptive behaviour including independence, self-help skills (e.g. dressing, toileting) and social skills. These may vary according to the age of the child.

The causes of intellectual disability can vary from genetic conditions, injuries, infections or problems around the time of birth. For many children however, no cause is found.

The age of onset for these conditions to occur is during the developmental period. A formal assessment needs to be carried out in order for a child to be diagnosed with an intellectual disability. This is completed by a psychologist or qualified professional in the assessment of cognitive and adaptive behaviour.

Children with intellectual disabilities must be below average in both measured intelligence and adaptive behaviour. The range of intellectual disability is from mild to moderate to severe. It is believed that children with intellectual disabilities can be greatly assisted by early intervention and appropriate education.

All children with intellectual disabilities will learn and develop new skills, albeit at their own pace. They will often need plenty of time to review and practice new concepts and skills.

Developmental Areas

Children may display some of the following characteristics

Social and Emotional Development

- May experience delays in learning skills of sharing, turn-taking and playing by the rules
- May exhibit frustrations through aggressive behaviours
- May become overly affectionate
- Child may develop self help skills more slowly and need reminders for toileting
- May exhibit immature eating habits

Physical Development

- Be aware that children may be hesitant to explore due to lack of confidence in their own skills
- May experience some sensory defensive behaviours
- Delayed gross motor and fine motor co-ordination

Language and Communication Development

- Ability to communicate dependent upon degree of intellectual disability
- Delays will be present in all children
- Communication skills require practice and repetition

Cognitive Development

- Delays in learning skills of concentration, memory and the ability to generalise
- May need to 'learn' skills to play such as sharing and turn-taking, how to enter play situations and appropriate things to say and do during play episodes

Intellectual Disability
Inclusion Strategies

Each child diagnosed with **Intellectual Disability** will be different and individual. It is important to gain information from the parents as to what characteristics of **Intellectual Disability** their child displays. It is important to work closely with the parents as well as any additional support specialists e.g. therapists who may be involved with the child. It is also important to gain an understanding from the parent as to what is the most important aspect of their child attending your service. What is it that parents hope to gain from using your service? The following inclusion strategies are just some examples which may be applied to support the inclusion process. This list is only the start and it is dependant on a variety of factors such as environment, length of time child is in care, child's interest, likes, dislikes and skills already achieved. The strategies are divided into developmental areas however some strategies overlap and assist in a variety of developmental areas.

Social and Emotional Development

- Find individual strengths and celebrate achievements
- Encourage play experiences and games that involve sharing and taking-turns.
- Support and respond to appropriate/desired behaviours in positive and consistent ways.
- Model appropriate behaviours.
- Encourage independence with self help tasks.
- Ensure the child has protective clothing for messy experiences.
- Use musical experiences for children to explore ideas and express feelings.

Physical Development

- Provide materials that the child is capable of manipulating including paint brushes, utensils etc.
- Model the use of materials for children e.g. playdough and encourage the child to manipulate materials themselves.
- Plan obstacle courses and outdoor experiences that encourage success e.g. low wide balance beams to walk along.

Language and Communication Development

- Use language that the child understands i.e. simplify language and use clear messages with one instruction at a time.
- Use clear positional and descriptive language.
- Use a range of communication strategies including pictorial and concrete representations.

Cognitive Development

- Use hands on/concrete experiences to increase concentration e.g. telling a story with props such as puppets or felt pieces.
- Extend children through experiences which they are most interested in and in which they experience the most success.
- Introduce challenges gradually and break complex tasks into smaller, manageable and achievable ones.
- Allow children enough time to complete tasks and practice skills.

References

Deiner, P.L. (1993) ***Resources for Teaching Children with Diverse Abilities - Birth through Eight.*** Harcourt Brace:

Gilbert, P.(1996) ***The A-Z Reference Book of Syndromes and inherited disorders—2nd Edition.*** Stanley Thornes (Publishers) Ltd: United Kingdom

Kozma,C. & Stock, J. (1993) ***Caring for every child—Ideas to meet diverse needs in Child Care***. Funded by the Commonwealth department of Human Services and Health: Sydney

Sydney Children's Hospitals Network (The), ***Intellectual Disability.*** http://www.schn.health.nsw.gov.au/fact-sheets/intellectual-disability NSW Health, NSW Government: New South Wales.

Umansky, W. and Hooper, S. (1998) ***Young Children with Special Needs*** Third Edition Prentice-Hall: New Jersey, USA:

Language Delay

Speech and Language delay in children can cause issues in communication, oral function and socialisation. The cause of language delay will vary from child to child and can be a result of hearing loss, physical impairments, brain injury or intellectual impairment. However, sometimes the cause is unknown. A child's communication is considered delayed when the child is noticeable behind in the acquisition of speech and language skills to that of his or her peers.

Communicating is the act of imparting and receiving information. This effective communication underpins all aspects of quality care. With a child who has a disability, communication is frequently a secondary disability. All communication has a developmental base and language does not develop in isolation.

Initially, it is important to have an understanding of the stages of communication in a child's development. There are four major elements within the process of language development:

- Inner language – ability to communicate with oneself. Developed by actively interacting and manipulating one's environment.
- Receptive language – ability to understand others. Child uses symbols to connect objects with their names.
- Interactive language – ability to synthesize information by classifying and requiring more than short term memory.
- Expressive language – ability to make oneself understood.

Effects on Developmental Areas

Social and Emotional

- May have minimum social experiences
- May experience difficulties making and keeping friends
- May become depressed
- May lack certain amount of independence
- May have attacks of rage and aggression

Motor and Physical Development

- May have developmental delay in physical areas

Language and Communication Development

- May have difficulty speaking
- May not understand or use appropriate forms of communication
- May have difficulty in making or expressing choices

Cognitive

- May have learning difficulties
- May not stay long at activities due to low concentration span
- May require instructions, directions etc. to be repeated 2 or 3 times and requires some time to process before responding or acting
- May have delays in skills of concentration, memory and ability to generalise
- May have difficulty understanding concepts of turn taking, sharing and how to enter into play situations

Language Delay
Inclusion Strategies

Each child diagnosed with **Language Delay** will be different and individual. It is important to gain information from the parents as to what characteristics of **Language Delay** their child displays. It is important to work closely with the parents as well as any additional support specialists e.g. therapists who may be involved with the child. It is also important to gain an understanding from the parent as to what is the most important aspect of their child attending your service. What is it that parents hope to gain from using your service? The following inclusion strategies are just some examples which may be applied to support the inclusion process. This list is only the start and it is dependant on a variety of factors such as environment, length of time child is in care, child's interest, likes, dislikes and skills already achieved. The strategies are divided into developmental areas however some strategies overlap and assist in a variety of developmental areas.

Social Development

- On arrival and farewell and when wanting child's attention say the child's name first to catch his attention e.g. "Jack, good morning" rather than "Good morning, Jack".
- Explain what you are doing when you are doing it when presenting an activity, giving instructions or encouraging turn taking/sharing.
- Provide a quiet area with objects for child to explore independently.
- Let other children know what child is doing to reinforce the concept of him being part of the group. Do this with all children e.g. "Look Jack is doing a puzzle as well".

Physical Development

- Keep things in the same place to assist child to be able to move from one place to another. If you change the environment walk and talk this through with the child.
- Count stairs, number of steps from each room to aid independence.
- Provide finger plays to encourage the use of both hands in a controlled manner as well as developing fine motor skills.
- Provide lock boxes and musical boards to promote finger and wrist movement and rotation.

Language

- Utilise the use of large clear pictures to reinforce what you are saying.
- Para-phrase back what the child has said.
- Clarify types of communication methods the child may use e.g. Makaton.
- Provide puppets/pictures as an extra prop when using finger plays and songs.
- Reduce the amount of instructions in one statement to allow time for the child to gain an understanding of what is been said e.g. “Hold the puppet up high” rather than “hold the puppet up high and wave it around so that all the children can see it.” Once child understands to “hold the puppet up high” you can then add “Good, now all the children can see it”.
- Ascertain from parents words that are familiar with the child e.g. family words that represent aspects of child life, and use these in your program.

Cognitive

- Encourage use of a bright easily recognisable bag for child to be able to recognise his hook/locker.
- Gain information from parents about child’s likes, interests and dislike and incorporate these in your program.
- Break tasks down to smaller steps e.g. placing one puzzle piece in a time rather than expecting the puzzle to be completed.
- Allow the child time to complete tasks and practice skills at own pace.
- Acknowledge level of achievement e.g. “you have placed that piece in the puzzle, well done” rather than just “Good boy”.

Reference

Aspen Reference Group — *Caregiver Education Guide for Children with Developmental Disabilities.* Aspen Publication 1997 ISBN 0834210347

Brownlow Andrea — More than Just Words *A handbook of Games and Activities to help include children with language and communication impairments.* Playcare PROGRAM & Dept Families, Youth & Community Care 1998

Disclaimer

Strategies to Support a Parent with a Child who is having Nightmares/Nightfears

Having nightmares and night fears can be quite normal for young children. The difficulty often occurs is that the child does not have the language to be able to express exactly what is happening. You as the parent talking and comforting are also increasing the child's vocabulary. It is very important to comfort the child and that the comfort occurs in the environment where the nightmare/terror occurred. Removing the child from the bedroom may only slow down the process of the child overcoming the fear.

Initial strategies:

- Observe and assess the environment i.e. the child's room. Spend time lying on the bed and trying to see what the room looks like to the child. What do the shadows convey? What do the pictures, toys etc. look like in the half dark?
- Spend time in the darkened room with the child using encouraging and descriptive words such as "how warm and comfy the soft light makes you feel" or "having those special friends (teddy) in the room makes me feel safe". What you are doing is helping the child to see his/her room as a very special safe place to be.
- Avoid highly active activities before bedtime.
- Establish a ritual with bedtime. There are different schools of thought whether "checking for monsters" is the best approach. This is best determined by you the parent remembering that a toddler has a very vivid imagination even if he/she cannot verbalise it.
- Often with the toddler age group imaginative play is very new and exciting. Utilise these interests to help the child settle and over come his/her fears of nightmares and terrors. For example, actively encourage your child to teach teddy/favourite soft toy how to go to bed and how to calm doll or teddy when they are upset or have had a bad dream. This will assist you to identify what works for the teddy or doll may also be of comfort for the child.
- Acknowledge the fear that the child has at the same time letting the child know that you are there and will protect them.
- Use the initial information through books and web site to gain an understanding of nightmares and night terrors. This will also help you understand what is occurring with your child in this context.
- Identify whether the child is having a nightmare or a night terror.
- Remain consistent with your strategies e.g. if you use a night light continue to do so.

References

Louise Porter *Children are people too* 3rd Edition Small Poppies
ISBN 0-646-4-122-X
Page 87

Susan Dodd *Managing problem behaviours* MacLennen & Petty
ISBN 0864330960
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www.dream.net.au/nightmares

www.parentkidsrights.com

www.chw.edu.au/parents/factssheets/nightmares_and_night_terrors

Disclaimer

Obsessive Compulsive Disorder

Obsessive Compulsive Disorder (OCD) is disorder that has been described since the 14th Century. Essentially OCD features recurrent obsessions or compulsions that are severe enough to be time consuming or cause distress or impairment. The obsessions or compulsion happen repeatedly and cause significant dysfunction thus limiting a person's ability to learn, work and make relationships.

The obsessions are intrusive and cause anxiety or distress if unable to follow through and the compulsion is the purposeful and repetitive behaviour that are performed in order to neutralize or prevent distress. Preventing distress can be undertaken by repetition of an act or avoidance.

OCD often starts in childhood with one in every hundred children diagnosed with OCD. The cause of OCD is unknown although on going research has identified that the brains of people with OCD work differently than those people without the disorder.

The disorder can be frightening for both the child and the adult mainly because the adult is unsure how to handle the situation. It is important that to be aware that some systems a child may display is in fact not OCD and caution needs to be in place for falsely diagnosing the situation.

Many rituals, avoidance behaviours, superstitious, nervous habits are part and parcel of child's normal development. It is when these rituals and such become time consuming, thereby preventing the ability to learn, work and grow, creating major stress and anxiety.

Effects on Developmental Areas

Social and Emotional

- May feel shame and embarrassment
- May struggle to make friends because their specific obsession e.g. view other children as dirty because of a hand washing obsession
- May withdraw or not attempt to make friends for fear of being found out
- May not play with friends outside as the bathroom is too far away

Motor and Physical Development

- May have developmental delay due to a reluctance to participate in physical games both gross motor and fine motor
- May display excessive habits of hair pulling and/or nail biting

Language and Communication Development

- May not understand or use appropriate forms of communication
- May have difficulty in making or expressing choices in a socially appropriate manner
- May over question to gain reassurance

Cognitive

- May have an excessive need to control the environment and behaviours of others
- May have fear of harming themselves
- May require instructions, directions etc. to be repeated 2 or 3 times to allay any concerns
- May have delays in skills of concentration, memory and ability to generalise

Obsessive Compulsive Disorder
Inclusion Strategies

Each child diagnosed with **Obsessive Compulsive Disorder** will be different and individual. It is important to gain information from the parents as to what characteristics of **Obsessive Compulsive Disorder** their child displays. It is important to work closely with the parents as well as any additional support specialists e.g. therapists who may be involved with the child. With the help from parents, identifying rituals, triggers and obsessive behaviour can be of help; not to change but to have an awareness to prevent the increase of anxiety. It is also important to find out if the child is under any form of therapy and whether the child is on medication. Medication can have additional effects to working with the child as some of the therapy and medication can tire the child out. It is also important to gain an understanding from the parent as to what is the most important aspect of their child attending your service. What is it that parents hope to gain from using your service? The following inclusion strategies are just some examples which may be applied to support the inclusion process. This list is only the start and it is dependant on a variety of factors such as environment, length of time child is in care, child's interest, likes, dislikes and skills already achieved. The strategies are divided into developmental areas however some strategies overlap and assist in a variety of developmental areas.

Social Development

- Explain what you are doing when you are doing it when presenting an activity, giving instructions or encouraging turn taking/sharing.
- Provide a quiet area with objects for child to explore independently.
- Let other children know what child is doing to reinforce the concept of him being part of the group. Do this with all children e.g. “Look Jack is doing a puzzle as well”.
- Provide small group activities i.e. one or two children to assist with development of friendship.
- Develop consistent rules and limits which are applied to all children in care.
- Talk to all children about differences including health problems, disabilities. Talking generally will assist in not singling the child with OCD out and assist children to have a better understanding and acceptance.

Physical Development

- Keep things in the same place to lower anxiety and stress. If you change the environment walk and talk this through with the child.
- Provide finger plays to encourage the use of both hands in a controlled manner as well as developing fine motor skills.
- Identify the compulsion as an indication when things are becoming stressful for the child. This will enable the adult to assist the child to move away and settle again.

Language

- Utilise the use of large clear pictures to reinforce what you are saying.
- Para-phrase back what the child has said.
- Reduce the amount of instructions in one statement to allow time for the child to gain an understanding of what is been said e.g. “Hold the puppet up high” rather than “hold the puppet up high and wave it around so that all the children can see it.” Once child understands to “hold the puppet up high” you can then add “Good, now all the children can see it”.

Cognitive

- Gain information from parents about child’s likes, interests and dislikes and incorporate these in your program.
- Allow the child time to complete tasks and practice skills at own pace.
- Provide consistent warning when preparing transition times.
- Reduce the outcome expectations of the child and focus on the process.

Reference

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Pedrick C.

www.betterhealthchannel.com.au

Disclaimer

Oppositional Defiant Disorder

Oppositional defiant disorder (ODD) is a childhood behavioural problem characterised by constant disobedience and hostility. Around one in 10 children under the age of 12 years are thought to have ODD, with boys outnumbering girls by two to one. ODD is one of a group of behavioural disorders known collectively as disruptive behaviour disorders which include conduct disorder (CD) and attention deficit hyperactivity disorder (ADHD). Early intervention and treatment is important, since children with untreated ODD may continue to be difficult and anti-social into their adult years. This can impact on their relationships, career prospects and quality of life. Some children with ODD will develop the more serious conduct disorder (CD) which is characterised by aggressive criminal and violent behaviours.

ODD behaviours usually surface when the child is at primary school but the disorder can be found in children as young as three years of age.

The cause of disruptive behaviour disorders is unknown but the quality of the child's family life seems to be an important factor in the development of ODD.

ODD needs to be professionally diagnosed by a child psychologist, child psychiatrist or a pediatrician specialising in behavioural disorders. Diagnosis involves detailed interviews with the child (if they are old enough), parents and teachers

Effects on Developmental Areas

Social and Emotional

- May have difficulty in making and sustaining friendships
- May have minimum social experiences
- May have attacks of rage and aggression and lose temper
- May deliberately annoy others
- May be touchy or easily annoyed by others
- May be spiteful or vindictive

Motor and Physical Development

- May have developmental delay due to lack of experiences

Language and Communication Development

- May not understand or use appropriate forms of communication
- May have difficulty in making or expressing choices in a socially appropriate manner
- May argue with adults
- May actively defy or refuse adults requests or rules

Cognitive

- May have learning difficulties
- May not stay long at activities due to low concentration span
- May require instructions, directions etc. to be repeated 2 or 3 times and requires some time to process before responding or acting
- May have delays in skills of concentration, memory and ability to generalise
- May have difficulty understanding concepts of turn taking, sharing or how to enter into play situations
- May often blame others for misbehaviour or mistakes

Oppositional Defiant Disorder
Inclusion Strategies

Each child diagnosed with **Oppositional Defiant Disorder** will be different and individual. It is important to gain information from the parents as to what characteristics of **Oppositional Defiant Disorder** their child displays. It is important to work closely with the parents as well as any additional support specialists e.g. therapists who may be involved with the child. It is also important to gain an understanding from the parent as to what is the most important aspect of their child attending your service. What is it that parents hope to gain from using your service? The following inclusion strategies are just some examples which may be applied to support the inclusion process. This list is only the start and it is dependant on a variety of factors such as environment, length of time child is in care, child's interest, likes, dislikes and skills already achieved. The strategies are divided into developmental areas however some strategies overlap and assist in a variety of developmental areas.

Social Development

- On arrival and farewell and when wanting child's attention say the child's name first to catch his attention e.g. "Jack, good morning" rather than "Good morning, Jack".
- Explain what you are doing when you are doing it when presenting an activity, giving instructions or encouraging turn taking/sharing.
- Provide a quiet area with objects for child to explore independently.

- Let other children know what child is doing to reinforce the concept of him being part of the group. Do this with all children e.g. "Look Jack is doing a puzzle as well".
- Provide small group activities i.e. one or two children to assist with development of friendship.
- Develop consistent rules and limits which are applied to all children in care.
- Choose reasonable punishments that actually teach a lesson and that can be enforced.

Physical Development

- Keep things in the same place to assist child to be able to move from one place to another. If you change the environment walk and talk this through with the child.
- Provide finger plays to encourage the use of both hands in a controlled manner as well as developing fine motor skills.
- Check how busy the environment looks with pictures on walls, things hanging from ceiling, activities on floor. Reduce the confusion with plain surfaces and defined areas.

Language

- Utilise the use of large clear pictures to reinforce what you are saying.
- Para-phrase back what the child has said.
- Reduce the amount of instructions in one statement to allow time for the child to gain an understanding of what is been said e.g. “Hold the puppet up high” rather than “hold the puppet up high and wave it around so that all the children can see it.” Once child understands to “hold the puppet up high” you can then add “Good, now all the children can see it”.
- Ascertain from parents words that are familiar with the child e.g. family words that represent aspects of child life, and use these in your program.

Cognitive

- Gain information from parents about child’s likes, interests and dislike and incorporate these in your program.
- Break tasks down to smaller steps e.g. placing one puzzle piece in a time rather than expecting the puzzle to be completed.
- Allow the child time to complete tasks and practice skills at own pace.
- Provide consistent warning when preparing transition times.
- Acknowledge level of achievement e.g. “you have placed that piece in the puzzle, well done” rather than just “Good boy”.
- Limit “screen time” i.e. any activity such as TV, Video games computers.

Reference

Kutscher Martin L. *“Kids in the Syndrome mix of ADHD, LD, Aspergers, Tourette, Bipolar and More”* Jessica Kingsley 2005

www.betterhealthchannel.com.au

BRAVE HEARTS

Responding After Disclosure – Some Helpful Hints

Some Do's:

Children who have supportive, caring, and understanding caregivers usually experience less ill effects than those children who do not. You play a very important role in your child's recovery by providing reassurance, safety and love; your child needs to know that you support them and that you believe them.

Below is a list of things you may choose to say to your child after they have disclosed sexual assault:

- "Thank you for telling me. I believe you".
- "I am sorry this happened to you".
- "You don't have to worry about taking care of me; the adults are responsible for taking care of things".
- "I know this was not your fault".
- "I am so proud of you for telling me; that must have been really hard to tell".
- "I am sad/angry/upset this happened to you. You may see me cry but that is ok. I am not sad/angry/upset at you at all and I can take care of myself".
- "This has happened in other families, we are not alone and we will get through this together".
- "I am sorry I did not realise this was happening to you. Now I know what you were trying to tell me".

Let your child know that you may need to tell other people about what has happened so they can help, such as the police, counsellor, teacher.

Remember that the experience of sexual assault often undermines children's sense of safety. Children may become more clingy, be afraid at bedtime, or need to have you near them more frequently, all of which are very common and normal behaviours. Children often need a lot of reassurance during this time so please do not fear you may be 'spoiling' them by giving them the security, reassurance, and attention that they need.

Some Don'ts:

When a child is sexually assaulted parents can often feel an array of emotions: sadness, grief, rage, disbelief, numbness, to name a few. You have every right to feel whatever you are feeling, and allowing yourself to be sad or angry or to cry shows your child that this behaviour is acceptable and reasonable. However, it is important to explain your feelings and reactions to your child when you experience them and to reassure them that they are not responsible for you feeling this way.

Children often believe they are the cause of everything that happens in their world and can feel they are to blame for your responses and reactions too. It is wise to keep explosive reactions and behaviours such as "I want to kill the ___" "This family has been destroyed" for other adults. Children can understand and deal with their care-givers emotions when they are not too overwhelming or scary.

Below is a list of things that can be unhelpful to a child after disclosure:

- Be careful not to put too many limits on your child's play or activities any more than you need to feel peace of mind – they may see this as a form of punishment.
- Don't make promises you can not keep, such as 'You never have to see him again', or that the perpetrator will get what they deserve/go to jail.
- Don't urge your child to 'forget about it'.
- Do not berate your child because they didn't tell you about the abuse sooner – children have very good reasons (both real and imagined) as to why they don't tell about their abuse and this type of questioning can increase their feelings of guilt.
- Don't ask them why they didn't say 'No'. This question assumes that the child had a choice in being assaulted. They didn't.
- Don't let your child feel as though they are responsible for any pain or disruption in the family because they told about what was happening to them.
- Do not to play the role of investigator and ask direct questions about the how's, what's and why's of the assault – sometimes children can not find the words, feel embarrassed, feel it's their fault, or feel the pressure in your reaction and may decide to 'forget' the whole thing. Also, this line of questioning is not helpful in terms of any police involvement there may be now or in the future.
- Don't assume they are lying about their experiences – children do lie, most often as a way to avoid punishment or getting into trouble, but they do not lie about sexual matters.

Behaviour – Sexual Issues for Children with Autism

Sexual curiosity and behaviours within young children are an integral part of development whether the child has Autism or not. The curiosity ranges from questioning, to looking at others, to "playing doctors" to imitating adult sexual behaviour. Through all these aspects the child is learning about his/her body, which is a positive approach to self esteem and learning to have respect for his/her own body as well as others.

Masturbation is an issue that can present behaviour problems at all ages. Working with children with Autism who masturbate can provide additional concern as the behaviour often occurs in inappropriate situations. For the adult it can cause concern in being able to explain and guide the child to understand that there is a time and place for everything. In addition, this kind of behaviour can create strong emotional reactions from adults due to the sexual and moral implications.

Boundaries and limits are a part of life. Children need boundaries and limits to help keep themselves, others and the environment safe. Guidelines establish clearly for children what it is you want them to do (e.g. Rule: "Don't run inside" is translated to Guideline: "We walk inside"). These same guidelines apply to children who masturbate at inappropriate times.

The development of strategies occurs over a period of time with a continual re-assessment of rules and limits established within the service. Rules are not necessarily changed for the skill level of each child, but adapted in the way in which they are presented and reinforced. The aim is to enable children to understand and participate in the process of enforcing the rules and limits. This process is an integral component in the development of children's social skills, communication and being a valued member of a group. In some cases, children with Autism, thrive on consistency of behaviours, rules and routines. As long as the adult is consistent with the rule and what is said, the learning often occurs and the child will be able to comply with the requests given. Bearing this in mind, reinforcing with a child with Autism that masturbating in public is not appropriate may require ongoing reminders and consistent distractions.

In approaching this behavioural issue it is important to take each child and his/her behaviours in context and respond according to your knowledge of the child and situation. It is important to be creative in your approach and open to learning from the child and yourself.

Food for Thought

- It is normal for all children to explore their bodies.
- Masturbation is a normal part of life.
- Some children have learned to comfort themselves by manipulating their genitals and will use this at sleep times, during stressful periods, changes in routines, environment and additional changes occurring within the family i.e. new baby in family, moving house.
- These attributes are normal for all children but may be exaggerated for a child with Autism due to the specific behavioural characteristics the child may present.
- If child is masturbating in his/her private space or in a private manner it rarely is a problem.

Each child diagnosed with **Autism Spectrum Disorder** will be different and individual. In regards to sexual behaviour issues for children with autism, it is important to gain information from the parents as to what characteristics of **Autism Spectrum Disorder** their child displays. The following strategies are just some examples which may be applied to support the behaviour guidance process. This list is only the start and is dependant on a variety of factors such as environment, length of time child is in care, child's interest, likes, dislikes, skills already achieved. The strategies are divided into developmental areas, however some strategies overlap and assist in a variety of developmental areas.

Suggested Strategies

- If the child is verbal, does he/she ask specific question about body parts, reproduction or intimacy? If so, aim to respond accurately and appropriately to child's developmental age. Avoid using nicknames about body parts and keep answers brief and simple.
- Observe the child when the masturbation occurs to assist in what may trigger the behaviour e.g. end of day, at rest time, anxiety, separation from parent, being excluded by other children, noise level of environment.
- If child is masturbating in front of others responses such as "You have found that feels good but I would like you to wait until nap time or when you are at home".
- Provide a child with other ways to comfort themselves such as carrying a cuddle toy, manipulating clay or other sensory materials.
- Aim to interrupt the behaviour without showing emotional reaction.
- Redirect the child to an activity that is incompatible with masturbation.
- Ensure that the child's clothes are comfortable and not too tight, too loose or twisted in order to avoid the child's attention to the genital area.
- Ensure that all staff are consistent with their response and direction to the point that all staff use the same words each time.

Additional Resources:

Autism Queensland

Provides a phone advisory service which enables staff or parents to discuss the concerns with an outreach consultant. This service is free of charge.
Ph: 07 32730000 and ask for Outreach Consultant.

Family Planning Qld.

Offers sexuality and relationship education services for people with disabilities, their parents/carers and professionals working in the disability field.
Phone advice is available.
One on one education is available in regional areas however there is a waiting list for this.
Ph: 07 33250 0240 to obtain your nearest regional office.

References:

Fouse B Wheeler M *A Treasure Chest of Behavioural Strategies for Individuals with Autism"* Future Horizons 1997

Hewittt D *"So this is normal too"* Working out developmental Issues in Young Children Redleaf Press Minnesota 1995

Sanders M *" Every parent"* A positive approach to children's Behaviour. Addison-Wesley 1992

Family Planning Queensland. www.fpa.com.au/factsheets

Stealing

Young children stealing from either the home or while in care is basically involving taking an item which belongs to another person or persons. Children at a young age of up to 4 years do not necessarily understand the concept of ownership as learning about possessions is not an easy task. Children are often told that they can't have or use an item because it belongs to Mum or the shopkeeper but at the same time are told to share and "let the other child have the item".

All humans, and that includes young children, have items and possessions that are important and precious. Some of these items are of no monetary value but have personal value which would be impossible to replace.

Sometimes adults allow children to take brochures, leaflets from shops but get cross if a child takes other items such as books or cards. The development of ownership, respect for others' property and understanding right and wrong is a difficult concept for children.

The adult's reaction to a child's behaviour when stealing occurs will play an important role in how a child develops the awareness and understanding of honesty. If an adult reacts negatively the child may begin to hide their actions of stealing.

Reasons why a child steals is a complex issue and continued stealing may indicate that it is a sign of emotional distress. A child losing their home, special valuable objects packed away, or a change of where the child lives can create emotional distress. Not only has the child lost their home but is now living in a different environment and there appears to be nothing around to provide the emotional support that their special possessions provided. Thus they search for something that will allow it all to go back to the way it was before. Taking pretty items belonging to adults or the centre is one way of trying to create a safe environment. Undoubtedly, with a family suffering emotional distress through a traumatic period only increases this uncertainty for the child.

Working with the parent to be consistent in reactions and guiding the child's behaviour, utilising resources of children's books that assist in creating the awareness and developing consistent approaches in how to react will assist the child during this time.

In approaching behavioural issues, it is important to take each child and their behaviours in context and respond according to your knowledge of the child and situation. It is important to be creative in your approach and open to learning from the child and yourself. The ultimate goal is to support the child to learn to be thoughtful and considerate in relation to both themselves and others.

Suggested Strategies

- Establish simple rules in relation to stealing e.g. do not take a toy/item from another person without asking.
- Aim to remain calm when the incident occurs. Use the incident to reinforce teaching about possessions and what the child has taken does not belong to them.
- Provide an opportunity for the child to access their own possessions to take with them when away from the home. For example, take the child to the storage place where the things are and help the child to choose a couple of items that can be taken to the grandparent's house. At the same time show the child that the precious possessions are safe and secure. Depending on the length of time they are in storage the child can change them over on a two weekly or monthly basis.
- Plan activities in which the child can practice co-operating, sharing and helping.
- Lead the child through discussions of feelings and being honest through use of pictures, stories or puppets.
- Provide the child with responsibility of items both at home and in childcare (e.g. being responsible for making sure that each family member has put their personal items away in a safe place at the end of the day or while in care, making sure that all the buckets for the sandpit are packed away together at the end of the day so they are ready for use the next day).
- When reading stories or discussing ownership, honesty, stealing etc ensure that this is done with the whole family/group of children so as not to single out the child. Other children becoming aware of a child who is stealing can easily be ostracised.

References:

Porter Louise *"Children are people too"* A Parent's guide to young children's Behaviour. Small Poppies SA. 2001

Sanders M *" Every parent"* A positive approach to children's Behaviour. Addison- Wesley 1992

Mukherji P. "Understanding children's Challenging Behaviour" Nelson Thornes 2001

Supporting Children with Separation Anxiety

Children's lives are always marked with transitions of change. Most of the changes that occur in a child's life are positive and part of growing up, such as a new baby in the family, moving up to the next group in day care, starting school, and changing houses. However there still can exist within each situation an anxiety if the child is separated from the adult he/she feels comfortable and safe with. Separation protest is a reflection of the child's fear of being separated from his or her primary caregiver. This fear can be transferred from the separation from the parent to separating from the caregiver. Most children have developed cognitively to cope with separation during stressful times. Some children may appear to regress which is initiated by a new factor occurring within their lives.

Suggested strategies

- **Work closely with the parents** – it is easier to establish a safe and consistent environment if the parent/s and the caregivers are working together. In consultation with the parent develop a consistent process on arrival and departure which reinforces with the child that the parent will return.
- **Connect with the parent** – initially it can be useful for the parent to provide the child with an item that belongs to the parent. The child is asked to look after that item until the parent returns at the end of the day. The item can be a piece of clothing e.g. scarf or something from the parent's bag. It is important that the child recognises that the item belongs to the parent but provide something that will not cause too much stress if lost during the day.
- **Reflect on arrival times** – observe how you and staff greet the child on arrival. Do you interact with parent; acknowledge the child is upset that Mum/Dad is leaving? Identify what you do to engage the child into the care environment. E.g. go to the window and wave goodbye, establish a routine task that you need the child's help with each morning.
- **Reinforce that the parent will return**- ensure both the parents have let told the child they will return. E.g. use the clock to say when the big hand is on … I will be there. Reinforce that they did return like they said they would.
- **Assess your program** – identify aspects of your program that triggers stressful behaviour by the child. Modify and change to decrease these triggers. e.g. if you start to notice that the child gets upset when you leave the room provide an activity or "job" to do while you are away such as "can you set up the blocks so that they are ready when I come back"

- **Connect the child with the parent** – Aim to aim to keep connecting the child with the parent e.g. "Mummy packed a really nice lunch for you today." Or "I really liked the shirt your Daddy was wearing …. Is my favourite colour".
- **Sharing your care**- Provide opportunities to let the child know that you do care for him but you also care for the other children. Use activities of turn taking and sharing to reinforce this concept.
- **Communicate to child what you are doing** – continue to tell the child what you are doing even if child continues to be upset. E.g. "I am going to get … up from his/her sleep so that we all can play together"
- **Identify child's interests** – aim to incorporate child's interests, likes or dislikes into the experiences you provide. Find out what the child did on the weekend or may be doing next weekend.
- **Visual Schedules-** utilise visual schedules to help the child understand what is going to happen next e.g. put my bag in my locker, go to window with adult to wave goodbye, get the buckets of crayons off the shelf to put on table or put the basket of props down near the teachers chair ready for group time.
- **Focus on relationship building through routines** –creating stable and predictable routines throughout the day lets the child know that while lots of changes may be occurring elsewhere here is a place that remains the same.
- **Support the child's social development** –provide individual or small group activities that assist in recognising all children in the group and value their individual skills and differences. E.g. activities that require turn taking. These activities can also focus on areas of the child's interests. When acknowledging a child ensure you say the child's name e.g. Jack is working with the blocks just like you, Ben.
- **Provide calming activities** – create calming environments such as waterplay, bubble blowing, relaxation CD's, quiet reading, quiet place for the child to retreat.
- **Initiate activities that encourages a child's interest** – e.g. if a child shows interest in a topic or certain art/craft area provide these activities. Gain the child's involvement by encouraging the child to assist in setting up these activities.

References:

Greenman J. "*What happened to the world*?" Helping children cope in turbulent times. Pademelon Press 2002 Australia

Disclaimer

Toilet Training

For parents embarking on toilet training as a new stage of development for their child, there can be a mixture of reward and frustration. The process can be short and sweet or a long ongoing battle between the parent and child.
There are no hard fixed rules for parents beginning toilet training, however there can be some consistent decisions made in how the parent approaches this new developmental task of their young child. The following information including cues and strategies are just a guide to help parents in successfully assisting their child to become independent in toileting. It needs to be remembered that each child is different and develops an understanding of their own bodies, instructions and skills at different rates. Toilet training can be an emotional time for parents. Parents often have feelings of guilt and shame (why can't my child be trained like all the other children), often experience power struggles, total frustration or anger with the open defiance of their child. It can be comforting to know that children will still become toilet trained in due time or rather in their own time. Exception to this may occur if the child has a developmental delay or some physical reason that prohibits the child from becoming continent.

Factors about Toilet Training

- If a parent becomes anxious about training, the child will pick up on the anxiety and may refuse to be trained.
- A child may copy older brother and sisters but the parent cannot force the pace.
- Learning to have control over your bladder and bowel is a complex task for a child. There are so many components to the exercise such as knowing the cues the body is giving, the physical task of removing clothes, wiping the bottom and washing hands. This is a lot to remember especially when all the child wants to do is be outside and playing.
- About 10% of 5 year olds still wet the bed at night.
- Bed wetting programs usually aren't recommended until the child is at least 7 years.
- A child may be toilet trained and then appear to regress at about the age of three. This may just mean that the child's concentration is longer and more focussed on what he /she is playing with and not be aware of the cues that they need to go to the toilet.
- New experiences such as a new baby, change of routine, visitors or changing into a new group at day care can cause a set back on the toilet training.

Suggested Strategies

- Try not to over emphasise the whole process. This can result into power struggles between the parent and child.
- Check to see whether the child shows fear or concern when the toilet is flushed. Help the child to see that they can't fall in (use a small toilet seat over the adult toilet seat).
- Create opportunities for the child to be without nappies from time to time, e.g. run out in the back yard. Disposable nappies are extremely efficient in absorbing fluids away from the skin. The child may not feel uncomfortable in a wet or dirty nappy.
- Let the child know that you have confidence in him and know that one day he will manage the toilet/potty successfully.
- Set the stage for progressing to using the potty/toilet while the child is still in nappies and required to lie still to be changed by allowing the child to be involved in the nappy changing process such as getting the nappies and handing you the supplies needed. This creates opportunities for the child to develop autonomy and it tells the child that you believe that child is competent in doing tasks.
- Avoid rewards and praise such as stamps or stickers or special treats. Encouraging statements and hugs are more beneficial in the long run.
- Keep lots of spare underpants and clothes to easily defuse the situation if and when an accident occurs.
- If a child is resisting being toilet trained, look for natural or environmental factors that may be affecting the situation. Stress in a child's life can affect a child's independence in toileting.
- It is important not to punish the child for any accidents that occur.
- Think about when you are saying "good boy or good girl" when they make it to the toilet. The child may perceive that if they have an accident then they are a "bad girl or bad boy".
- Seek out information from the childcare service your child attends in regards to the policy of toileting. Knowing what staff do may assist in gaining a consistency in approach both at home and in care.

References:

Porter Louise — *" Children are people too"* A Parent's guide to young children's Behaviour. Small Poppies SA. 2001

Nelsen Jane
Erwin Cheryl
Duffy Roslyn — *" Positive Discipline – the first three years"* Prima Publishing 1998

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