CALLED TO SERVE: SERVICE-PROVIDERS OF CHILDREN WITH SPECIAL NEEDS

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Introduction

Special education concerns have expanded through the years, but formal classroom teaching comprises only a fraction of the care that should be extended to children with special needs (CSN). There remain a lot of people who do provide care and service to CSN, but their job is often a relatively forgotten and unknown one. These are the CSN caregivers and service-providers who work as employees in social welfare centers, rehabilitation centers, hospitals, orphanages, and similar such institutions.

Unlike special education teachers who are only with CSN in their classrooms, CSN service-providers are with them in the most personal, intimate, and delicate moments in the lives of CSN. In this regard, they can "touch the heart" of the care-needing and service-needing CSN more than the teacher. Special education schools and institutions have to train them to enhance and improve their skills in responding to the social, emotional, and educational needs of the CSN.

The information about CYSN service-providers

A survey questionnaire was devised containing 14 items, some of them open-ended and some more of the sentence-completion item type. The aim of the survey was to probe the concepts, feelings, and experiences of the care and service-providers while taking care and providing service to CSN who are staying or housed in the centers.

Pilot testing was done and the question items refined. Professors of the UP Special Education Area administered themselves the questionnaire to 174 respondents (Rs) who were working in 12 center sites, all located within Metro Manila, except for one in Batangas Province. These 12 center sites, arranged according to number of Rs, were:

1. Marillac Hills (MH), Alabang, Muntinlupa City (26)
2. Boys Town (BT) Complex, Parang, Marikina City (21)
3. Sanctuary (SC) (20)
4. MYRC, Arroceros St., Manila (18)
5. Elsie Gaches Village (EGV), Alabang, Muntinlupa City (17)
6. Haven for Children (HFC), Alabang, Muntinlupa City (16)
7. Rehabilitation Sheltered Workshop (RSW), NCR, Project 4: (15)
8. Day care centers (DC), Lobo, Batangas (14)
9. Caloocan City day care centers (DC) (10)
10. National Vocational Rehabilitation Center (NVRC), DSWD, NCR (7)
11. Nayon ng Kabataan (NK) (7)
12. Day care center (DC), BASECO Compound, Manila (3)

The survey findings

Nature of job of CSN providers in the centers

The first item asked the Rs to describe the work that they were doing in their center. The question was posed in order to identify later specific duties and responsibilities of each CSN service-provider.

Of the total 174 Rs, the bulk (some 40%) answered that the nature of their work was home management. About one-fourth were teaching, closely followed by those in case management. These three categories of center employees made up nearly three-fourths of the total Rs. The remainder, in smaller percentages (ranging from six to one percent), were in administration/supervision, health services, support services, psychological services, activity therapy, security, and legal matters.

Very valuable information came from the Rs' answers. Those in home management gave the following responses:

- *Kami ang tumatayong magulang ng mga batang ito. Kami ang gumagabay sa kanila pang-araw-araw. Kami ang may direct contact sa kanila. Kami ang naghihikayat sa kanilang kalimutan ang masaklap nilang nakaraan at muling mangarap at magbigay ng pag-asa* (We stand as parents to the children. We guide them everyday as we are in direct contact with them. We persuade them to forget the sad things of the past and to dream and to hope).

- *Pinapatnubayan ko sila upang maging maayos ang kanilang kalagayan sa hinaharap* (We guide them so that their future may be taken care of).

- We give them love which their biological parents could not give.

- We give them hope as part of their home management duties.

- *Mapasensiya kong tinutulungan sila. Maalalahanin ako sa mga pangangailangan nila* (We show patience as we assist them. I am concerned with providing their needs).

- We take charge of advising them about proper hygiene, of supervising household activities like preparing meals and washing dishes, and of reminding them about their daily schedule.

- We monitor the CSN (*I make it sure that they are safe and I monitor them round the clock. These are my duties aside from helping them clean*).

Those in teaching (almost 19%) gave less elaborate data, which oftentimes, were just written in phrases. Among their responses were:

- Teaching basic skills like reading, writing, and counting,
- Teaching specific age groups (4-7 years old),
- Teaching functional literacy,
- Two said "*May puso ako sa bata*," which showed their emotional attachment.

Case management employees (16.68%) were the social workers whose work aimed at identifying the needs of the client and also identifying and implementing the program fit and proper for them. A social worker said, "We are the case managers of the clients, responsible for their rehabilitation and development. We work out … (the CSN's) disability acceptance and motivate them for independent living." The aim of rehabilitation is for CSN to be functional in the future.

Those in administrative/supervision (6.32%) take charge of the administrative units, making sure that production is done properly. They handle training and supervise the implementation of other projects. One handles the canteen, another supervises projects and looks for the funding aspects of the projects.

The centers have their doctors, nurses, and other health professionals making up the health services of the centers (5.74%). They conduct physical examinations, treat specific diseases, interpret laboratory reports and determine the fitness of CSN. They also give lectures to the staff. Nurses dispense medication, provide basic health services, and refer clients to hospitals.

Support services (4.6%) consist of employees who do the purchasing, cooking, clothes washing, serving as drivers, helping in bathing children, cleaning, and assisting in processing reports.

Psychological services (3.45%) include the administration of intake interviews, psychological tests, and do counseling work. Group sessions are done to help the CSN process their concerns

Physical therapists (1.72%) provide recreation to CSN. They identify physical activities for clients. A therapist said that his job entails the enhancement of skills that prepares the clients for independent living. Security (1.72%) takes charge of peace and order in the center, if not escorting children in conflict with the law to court to attend hearings. The one female legal officer handles the writing of motions for children in conflict with the law.

Characteristics of CSN

Majority of the Rs (52.3%) said that CSN are those with **specific** needs. As to what these specific needs are, the Rs pointed out love, understanding, and care. One respondent put it in Filipino, "*pang-unawa, kalinga, pagmamahal*." They also need food. They need medicine and rehabilitation. In rehabilitation, two Rs pointed out the need to give "*sapat na kaalaman sa pamamagitan ng* accessibility, training, *at* assistive devices *para ma*-mainstream (adequate knowledge through accessibility, training and assistive devices to mainstream them).

A second group of Rs (28.16%) said that CSN have a disability. They are people "with defects," such as lacking in their mental capacity ("*kulang sa pag-iisip*"). This seems to be a widespread view among Filipinos. Disabilities particularly cited were visual impairment, deafness, and epilepsy.

The next group of Rs (12.07%) looked at CSN as victims of abuse. Those who experienced sexual and physical abuse/exploitation suffer from trauma. The same case with abandoned, orphaned, neglected children who have become homeless and rescued from the streets.

Other Rs (2.87%) said that CSN are those with family problems – broken families, absentee parents, and because of this, they go the wrong path ("*naligaw sa landas*"). Also, they are children in conflict with the law.

Only a few Rs described CSN as having emotional and behavioral problems or that they have committed criminal offenses.

Causes of disabilities of CSN

Coming out as the top cause of disabilities (14.74%) was the parents, because they were irresponsible, negligent, and immature. Next causes include: genetics/heredity/blood incompatibility (11.3%), poverty/financial inadequacy (10.07%), environmental influence of neighborhoods (6.88%), accidents/biological and environmental hazards (6.73%), lack of awareness/information/knowledge (6.14%), inadequate primary health care (5.65%), malnutrition (5.16%), dysfunctional family (4.91%), and abuse/maltreatment/molestation (4.57%), and sickness during pregnancy (4.42%). The rest were minor causes as cited by at least one to two percent of the Rs.

Description of CSN disabilities

Classified into types of disabilities of people with special needs, the most frequently identified was mental retardation (Down syndrome), according to 18.4% of the Rs. Next disability types were: orthopedic impairment and physical handicap (14.93%), visual impairment/blind/poor eyesight (9.72%), hearing impairment/deaf (8.68%), commission of crimes (6.60%), sexual/physical abuse and exploitation (6.25%), insanity (mental illness/psychosis) (6.25%), and autism (5.56%). As can be noticed, the causes generally fall into mental deficiency, physical deficiency, and then the social environment.

It is very interesting that 17.36% of the Rs wrote inappropriate responses, such as mentioning about the elderly when the survey is about the youth, citing the role of assessment, that there should be no categories, attempting to come up with categories of the disabled, and even defining "children with special needs." This indicates confusion if not lack of knowledge about the types of CSN.

Description of the physical, socio-emotional, intellectual, independence/self-reliance aspects, and other aspects of CSN.

Physically, CSN were mainly described in reference to presence of physical disabilities, handicaps and limitations (36.11%), compared to its opposite, the healthy and able-bodied (20.37%), followed by the unhealthy (18.52%), with sensory disabilities (5.56%), and who were dirty and untidy (5.56%). Physical description in terms of ability to work and other people's social-emotional reactions elicited very few responses only.

Socio-emotionally, a big majority of Rs (67.81%) associated the CSN with negative personality traits and behaviors (emotionally weak and unstable, unable to cope with problems, sensitive, shy and quiet, loners or withdrawn, depressed, and may experience extremes of emotions). On the other hand, CSN also exhibited positive personality traits and behaviors, with 24.54% of Rs saying so. The positive traits/behaviors included: being sociable, friendly, loving, obedient to elders, kind, happy, patient, trustworthy, brave, emotionally strong, goal-oriented, helpful, industrious, religious, and thoughtful.

Intellectually, CSN were described as intellectually deficient (55.62%), smart (26.97%), with average intelligence (10.11%). Only a few described them as having attained a low level of education (6.18%). As deficient intellectually, the words Rs used to describe were: slow learners, mentally retarded, below average intelligence and *mabagal mag-pick up*. When perceived as smart, they were described as: *matalino, may sariling diskarte, magaling sa school,* can learn quickly, think and understand, observant, easy to teach, inquisitive.

On the measure of independence/self-reliance, CSN needed training and supervision (42.65%) and were dependent on others (35.29%). In contrast, they were also described as independent (20.59%) and able-bodied (1.47%).

As to other characteristics, CSN were described as mostly talented and creative (50%).

Important needs in life among CSN

Children with special needs need most acceptance, love, care, attention, and support from the family and significant others (36.85%). Then, they need education and training (14.32%), understanding and patience (14.08%), the basic human needs which mean food, clothing, shelter, and finances (12.91%), guidance and counseling, including emotional needs (5.87%), and employment/self-employment (4.69%).

Only 1.88% of the Rs mentioned that they need medical attention/medicines and safety/security/protective custody.

Belief in CSN being capable of receiving training and eventually becoming productive

All Rs believed that CSN have capabilities and, thus, become productive individuals in the future. Ask why they believe so, the responses of the Rs can be categorized into four groups:

1. Intrapersonal factors of the CSN themselves (45.31%) because they have the talents and skills and have the abilities to think, learn and follow instructions,
2. Rights-based factors (25%) since they know that their right for education and training will be a plus factor in their demand to enhance their capabilities,
3. Circumstances needed for their productivity (24.22%) as time, opportunity, encouragement, basic needs, and love exist, which encourage them to value enhancing their capabilities, and
4. Other factors (14%), such as their being challenged knowing that they have been victims of circumstances, along with the success stories of some CSN that serve to inspire them.

Ways in which CSN may be productive

The responses may be grouped into: 1) avenues where CSN can be productive, which comprised 50.89% of the responses, and 2) conditions necessary for their productivity, which obtained 49.11% of the responses.

Avenues of productivity responses included: use of talents/skills, employment, livelihood, assisting/helping others, and skills/training in arts and crafts. Conditions necessary for productivity included: general education and training, guidance, vocational assessment, and efforts/industriousness/obedience of the CSN.

Most effective strategies in rendering assistance/intervention to CSN

The responses were found to cluster into three groups: 1) strategies which were teacher-related, 2) strategies which were learner-related, and 3) specific strategies.

Of the teacher-related strategies, most Rs mentioned giving love and affection to CSN. The next strategies were: maintaining good rapport with them, giving them time and attention, respecting them, giving them emotional support, trusting them, and treating them as children of God.

Of the child-related strategies, many Rs pointed to the skills that CSN needed: socialization skills, life/ADL skills, and academic skills. Skills training for employment purposes was important as well as the teaching of values.

Specific strategies cited were: classroom dynamics such as direct guidance and supervision, grouping styles, inclusion, and individualization. Strategies may have to include collaboration between the family, the community, the medical and employment services, and the center.

Rs may not have a clear idea of what "strategies" were on the basis of their answers. Sixty percent of the responses were about attitude and knowledge of the teacher.

Advice to future teachers of CSN

Rs shared the following advice to future teachers of CSN:

- Understand them,
- Love them,
- Be patient with them,
- Be a good person,
- Accept them, and
- Love your job.

The first five answers were about teacher qualities and tasks. The last related to attitude.

The good points and strengths of CSN

The Rs pointed out certain good points/strengths of the CSN, among them:

- special abilities and talents (27.06%),
- capable of and eager for leaning on being trained (15.81%),
- capable of living normal lives and determined to live like regular individuals (11.22%),
- friendly, loving, and affectionate (9.70%),
- disciplined, responsible, and reliable (7.14%), and
- compliant, cooperative, and understanding (6.63%).

Extent that CSN contributed to the development of service-givers as a person

The almost daily encounter and communication with CSN have also influenced service-givers in the following ways:

- They became more patient and understanding,
- They felt grateful, fortunate, blessed,
- They grew mature and improved themselves personally,
- They were inspired to strengthe4n their commitment, and
- They felt a sense of accomplishment, fulfillment, and satisfaction.

Problems in working with CSN

Majority of the problems encountered by support service-givers with CSN were behavioral issues. These behaviors included quarrels and fights, temper tantrums, distractions caused by others during sessions, physical aggression towards others, and lack of motivation to participate in activities. These behaviors, as one may notice, are all non-positive, which may be frustrating to adult care and service givers. As mentioned by some Rs, the causes of these were lack of attention and guidance, non-visitation of their parents/relatives, depression, low self-esteem, and frustration.

The second most frequent problem involved family issues. The CSN came from unfortunate situations wherein they experienced rejection and deprivation of family love. In fact, their parents have failed to exercise their obligations to their children. Due to this, non-positive behaviors emerged.

A third set of problems had to do with health. These included physical manifestations of the ailment (such as seizure attacks) to their psychological reactions to their social environment (like depression, lack of self-esteem, not being able to accept one's condition, lack of hope). There are also problems like misunderstandings among CSN given personality differences as well as communication problems.

The varied concerns of caring CSN makes the tasks of service-givers a multiple, all-around job.

Besides the problems of the CSN, other problems exist that may relate, affect, and compound their problems in direct and indirect ways. These problems had to do with the center and with the community.

Problems with the center included: 1) lack of funds to buy food, clothing, medicine, teaching tools, and books to improve the facilities in teaching and training the CSN, 2) lack of cooperation of the CSN's family, and 3) lack of doctors and trained personnel to handle the special clients.

Problems with the community related to: 1) lack of employment opportunities or CSN, 2) community discrimination, and 3) government unable to prioritize CSN programs to support their education, training, and rehabilitation.

Earnest wishes for CSN

The wishes of the Rs for CSN in the centers may be grouped into five areas: 1) normal life, 2) independence and self-reliance, 3) change in character, attitude/values, 4) education, and 5) physical/medical and social needs.

Most service-givers wished CSN to lead a normal life in the future. Rs wished them a new life, that they find hope and remain positive, and become happy. Wishing for their independence and self-reliance were about taking the life of functional individuals who can have their own employment, means of subsistence, or having a family of their own.

Wishing for a change of character/attitude/values include becoming strong to face challenges, learning to be a better person – more respectful, truthful, well-mannered, and fearful of God. Wishing for their education means that CSN continue finishing their schooling in the center, acquire skills that they may avail of later in their adult life. Wishing for their physical/medical and social needs means CSN be healthy and have a long life.

Conclusions

The survey tapped the responses of 174 service-givers working in social welfare institutions (rehabilitation centers, boys town, day care centers, and the like) mostly in Metro Manila and day care centers in one municipality of Batangas Province. The conclusions of the survey are as follows:

Nature of service-givers' job: mostly in home management
Description of CSN: they are those with the specific need for love, care, and understanding
Causes of disabilities of CSN: the parents themselves followed next by genetic abnormalities
Description of CSN's disabilities: mental retardation
Capability for training: CSN have their own talents and skills. They also have the ability to think and learn
Ways in which CSN may be useful: use of their talents/skills via general education and training at the centers
Most effective strategies: giving love and attention; giving them skills for an adult life
Advice to future teachers of CSN: understand and love them

Good points/strengths of CSN: special abilities and talents and their eagerness to learn

Extent to which CSN contributed to the development of service-givers: service-givers became more patient and understanding

Problems in working with CSN: mostly about their negative behaviors

Earnest wishes for CSN: that they lead a normal life in the future

NATURE AND CHARACTERISTICS OF CHILDREN WITH SPECIAL NEEDS

Marie Grace A. Gomez and Irene C. Oael

Who are the children with special needs?

The term "children with special needs" (CSN) refers to male and female children whose physical-motoral, cognitive, language, psychosocial, and independence levels markedly differ from the average or regular children of the same age. They may be blind, deaf, or physically disabled since birth, conditions which limit their physical capabilities and make them different from the rest. Mentally, they may demonstrate delayed behaviors that are indicative of low or undeveloped intelligence (APA, 2000), or unique artistic, creative, and intellectual gifts or talents (Booth & Statam, 1998; Camara, 2002). They may differ in terms of language abilities, impeding communication, or social-emotional and self-care skills and maturation.

These are the children many people refer to as those with special needs. It must be remembered, however, that there are different kinds of disabilities. Some disabilities may create difficulties in understanding things. Other disabilities create communication difficulties or difficulties in relating with others. It is important though that despite the presence of a disability, the CSN can still learn and grow.

Philippine laws (RA 7277, PD 603) provide that children and youth with special needs, between 0 and 21 years of age, correspondingly have special education and rehabilitation needs. They need special education because they differ from the regular or average child in terms of: 1) mental characteristics, 2) sensory abilities, 3) neuromuscular or physical characteristics, and 4) social abilities. These four categories of children and youth with special needs also have sub-categories, namely:

A. Children and youth with intellectual/mental and leaning disabilities
    1. Intellectual disability (Mental retardation)
    2. Learning disabilities
B. Children and youth with sensory and communication impairments
    1. Deaf and hard of hearing (hearing impairment)
    2. Blind and low vision (visual impairment)
    3. Speech and language disorders/delays
C. Children and youth with physical and health impairments
    1. Physical/orthopedic impairments
    2. Special health problems
D. Children and youth with social, emotional, and behavioral problems
    1. Autism
    2. Attention deficit and hyperactivity disorder (ADHD)
    3. Behavioral problems

Each group/sub-group is described based on the following:

A. The disability characteristics as generally perceived and understood,
B. The causes of the disability, and
C. The potentials for:
    1. learning,
    2. performing physically and/or working,
    3. taking care of oneself, and
    4. relating with other people.

Children with intellectual/mental and learning disabilities

Intellectual disability (Mental retardation)

Gretchen is a 10-year old girl who thinks like a four-year-old. She barely reads, forgets the names of the primary colors, and is slow in understanding the things around her. She lags behind in comprehending cause-and-effect

relationships, logical reasoning and making social judgments. Thus, for example, she has no concept of danger as she crosses the street, not minding if speeding vehicles may hit her. She also has difficulty understanding instructions.

Kristine has Down syndrome. In school, classmates tease her "mongoloid." They hide her things for the fun of it and some even hit her for her clumsy ways. They laugh at her whenever she gives wrong answers but she does not understand why they are laughing at her.

Disability characteristics. Individuals with intellectual disability have been called as "*sintu-sinto*," "*kulang-kulang*," "mongoloid," or "slow-learner," among others. Easily noticeable are the children with Down syndrome although they comprise only about five to six percent of total intellectual-disability cases. Physically, they have upward slanting eyes, very low nose bridge, protruding tongue, short neck, a body usually smaller than children their age, and are obese.

Intellectual disability refers to below average mental ability and capacity to perform everyday activities. It comes in different forms. Some of them do exhibit physical indicators of mental delays.

Causes. Intellectual disability is not a mental illness nor a disease. It is not communicable but it is not treatable. To know what commonly leads to this condition is important to be able to prevent its occurrence. The causes of intellectual disability may be grouped into three:

1. Pre-natal (before birth). These may be due to inherited genes, such as the abnormalities in the Down syndrome, diseases of the mother like rubella and syphilis, and the mother's alcoholism.
2. Peri-natal (during birth). The child exposed to physical trauma and oxygen deprivation during prolonged labor of the mother may suffer from brain defects.
3. Post-natal (after-birth). After birth, the infant may acquire infections (encephalitis, meningitis), may take in substances that cause

intoxication (lead and mercury poisoning), or may suffer from malnutrition, head injuries, and lack of environmental stimulation, all of which can lead to intellectual disability.

Ability potentials. In terms of level of support needed, children and youth with intellectual disability are categorized as mild, moderate, severe, and profound. In general, they are delayed in almost all areas of development and therefore suffer from several limitations.

1. Ability to learn. These children and youth have difficulty focusing and keeping attention. They also have trouble remembering information and making generalizations. Mathematics problem solving is very well below their ability to understand. Speech and language problems are also common. They need external motivation and usually depend on others in doing tasks and in moving around. Their academic performance is some three to four years behind children their age. They will never be able to catch up with their peers. This is not to say that they cannot learn. If their condition is not severe, they may do well in areas that do not require much academic skills. Still, the speed of their learning is slow. Instructions have to be simplified or repeated a lot. To be able to pursue further independence, they can be taught skills such as writing their names, recognizing commonly used words, counting money, going from one place to another, using community facilities and services, and other practical living skills.

2. Ability to physically perform and/or work. Intellectual disability may delay motor development or muscle movement in some individuals, which affects their speed and skill in performing some tasks. They may also have poor body control which explains their clumsiness.
   But if they are able to learn, they can do perform practical tasks. Though one intellectual disability that is closely associated with

congenital heart disease and other respiratory diseases, such as Down syndrome, the individuals affected – with provision of vocational training – are generally fit for work in specific settings.

3. Ability to take care of oneself. Basic self-care skills such as hygiene and grooming, eating, dressing, and toileting may be taught depending on the severity of the condition. Though some individuals can get employment, the extent of their independence can never be similar to those of the average youth their age.

4. Ability to relate with other people. In general, these individuals prefer the company of younger children. But they can also relate well with other people. It is their language problems alongside analytical lags which make social interaction with others difficult. If not taught what, where, when and how certain actions and feelings should or should not be displayed, they may behave inappropriately and disruptively.

Learning disabilities

Melai is a girl who performs poorly in school. Her classmates call her "*tanga*," "*bobita*," or "*walang alam*" because she does not answer teachers' questions. As a child with cognitive disabilities, Melai has a difficulty in understanding her lessons and in doing tasks. Some have difficulty in spelling and writing. Others have difficulty solving mathematics problems. Still others have difficulty understanding directions, reading, and comprehension.

Disability characteristics. Generally, *c*hildren with learning disabilities have normal mental ability and have no psychosocial and self-care delays. But they have difficulty in listening, thinking, speaking, reading, writing, spelling or doing mathematical calculations. The disabilities do not usually appear during their early schooling but they become increasingly noticed as these individuals go to the next higher grade levels when academic expectations are much greater.

Studies show that the structure and processes of the brain of individuals with this disability leads to problems in performing the aforementioned activities. Learning disabilities may persist through adulthood. Some children are called "learning disabled" when the truth is that they only suffer from maturation delay. Learning disabilities are also more common among boys than girls.

Causes. Factors like genetic links, the mother's alcohol use, problems during her pregnancy, and inhaled poisonous substances from the outside environment have affect the brain development of individuals that may lead to learning disabilities.

Ability potentials.

1. Ability to learn. Differences in learning exist among children with this disability. Some have problems in seeing and remembering. Others have difficulty in distinguishing sounds. Still others have poor motor skills. They tend to be disorganized and impulsive. They may not focus long on activities that they are doing or are asked to do.

2. Ability to physically perform and/or work. Most are able to find careers appropriate to their abilities. Some are able to reach and finish college if provided an intensive and long-term educational support. Others go into technical and vocational training. If taught how to avoid their own weaknesses, they are able to work competitively with people without marked evidence of their disabilities. So that they can sustain staying on in a job. Internal motivation and a very supporting environment are needed.

3. Ability to take care of oneself. They are able to do so but they need to take more active control by making their own decisions for their future.

4. Ability to relate with other people. Not all children and youth with a learning disability have social-emotional problems; only those who have experienced rejection or have a poor self-confidence may have such problems. Some are not able to read social and emotional signs in others such that they appear insensitive to other people's feelings. They may have difficulty understanding another person's point of view if verbal comprehension deficits are observed.

Children and youth with sensory disabilities

Children who are deaf or blind suffer from sensory disabilities. Gelai for example, did not respond when her mother, Aling Malou, called her by her name. She did not seem to listen when her mother told her something. Aling Malou consulted an audiologist and found out that Gelai had profound hearing loss.

Sam, who is totally blind, uses his slate and stylus to write in Braille. He reads with the feel of his fingers. When he goes around their community, he has to use a long white cane to give him a sense of direction and movement.

Angel has to use her magnifying lens in order to read. She cannot read ordinary text. Everything has to be in large print. She suffers from low vision. Despite her difficulty in reading, Angel goes through the activity as patiently as she can.

Blind and low vision (visual impairment)

Disability characteristics. The visually impaired are those who have difficulty performing visual tasks even with the provision of corrective eye glasses. They include the totally and partially blind (low vision), and those who use large print reading materials and other aids and devices to improve their sight.

Causes. Most common causes of serious blindness are eye diseases such as glaucoma, cataract, and diabetes. Among children, heredity and genetic abnormalities may bring about impairment in one's sense of sight. Infections

may damage the eye structure. Accidents also likely create injuries to the eye. Exposure to too much oxygen when babies are born prematurely is another reason for blindness among infants.

Ability potentials.

1. Ability to learn. What is affected is the means by which blind children receive information. If instruction is modified so that they will not need or not minimize the use of their eyes, then blind children may do very well in their studies. Proof of this is Roselle Ambubuyog who graduated *summa cum laude* from the Ateneo de Manila University.

2. Ability to physically perform and/or work. Most blind individuals are able to work as long as they are taught the necessary knowledge and skills. Some adult blind people earn money by learning the standard massage techniques after some period of training.

3. Ability to take care of oneself. The main concern with blind children and youth is mobility. If taught to find directions and if provided by a guide, they are able to perform most of the tasks of taking care of themselves. These include taking a bath, preparing their own meal, and choosing their own clothes.

4. Ability to relate with other people. Blind children and youth do not visually respond to those around them. Thus, the proper response behavior need to be taught to them such as turning toward the source of the voice and touching appropriately for physical communication. They prefer their own company of blind individuals but they are also able to establish good relationships with others who have normal sight.

One other concern is the sexual relationship of the blind youth. Since they depend more on their sense of touch, or tend to use their sense of touch when communicating, they may easily have the urge for physical contact; hence, their relationships with the opposite sex need to be monitored.

Hearing impairment

Disability characteristics. The hearing impaired includes the deaf and hard of hearing. The deaf is one whose hearing organs are not functioning. The hard of hearing has a sense of hearing; only that it is defective. In this case, his or her sense of hearing may be functioning even without using a hearing aid. Others really need a hearing aid to be able to hear sounds.

Causes. Different factors cause hearing impairment. One may be congenitally deaf; another may have acquired such deafness. Hearing loss can run across generations and some hearing impairments hereditary. Some impairments are due to diseases that the mother may have contracted during pregnancy or by the child at an early age. Environmental causes include noise, head injuries, and improper use of prescription drugs by mothers.

Ability potentials.

1. Ability to learn. The mental development of children with hearing impairment is the same as those with a normal sense of hearing. Difficulties in learning how to speak arise because they do not have access to hearing the sounds of language perfectly. They do not have an available guide on how to speak effectively. One way they can communicate with other individuals with hearing impairment is to learn and use the sign language.

2. Ability to physically perform and/or work. The deaf are able to perform well in school and in workplaces. With proper skills training, they are able to function well.

3. Ability to take care of oneself. The hearing impaired are able to perform their functions well as long as they are provided with the means of receiving information other than through their sense hearing of organ.

4. Ability to relate with other people. Even though they have some means of communicating with others, the deaf still tend to be susceptible to socio-emotional problems. They may have difficulty expressing themselves among hearing people because of their oral language limitations.

Speech and language disorders/delays

Disability characteristics. A person with a speech and language disorder/delay tends to draw unfavorable attention to their manner of speaking rather than to the idea that they are trying to communicate.

Causes. Speech and language problems usually occur with other disabilities such as intellectual disability, autism, learning disabilities, cerebral palsy and brain injury. It may be caused by damage to the brain or other nerves, by developmental abnormalities such as in cleft palate, and by environmental toxins known to cause speech disorders. Others have no known causes.

Ability potentials.

1. Ability to learn. Persons with speech and language disorders/delays have problems performing well in school due largely to difficulties in expressing themselves. Since language development is closely tied up with cognitive development, the deficits may mean delayed ability to

learn tasks such as following instructions, understanding main ideas, categorizing concepts/ideas, sequencing events, etc.

2. Ability to physically perform and/or work. Generally, they are healthy and are able to work once equipped with the means to understand and to express language.
3. Ability to take care of oneself. Due to receptive and expressive language difficulties, they may need to be taught how to comprehend instructions on performing adaptive daily living skills or participating in team games.
4. Ability to relate with other people. Their poor communication skills may impede building effective relationships with others.

Children and youth with physical impairments and special health problems

Physically/orthopedically impaired

These children have deficiencies in some parts of their body (Pierangelo & Giulianni, 2006). For example, Marco's right leg is shorter than his left leg. The children in his community call him "*pilantod*." He limps and has difficulty in walking. He is often late for school because he finds it difficult walking up to the second floor where his classroom is.

Children with physical disabilities may not just have one arm or one leg. Some may lack fingers and toes. One arm may be shorter than the other, or one leg may be thinner than the other. Despite these limitations, they can perform well in academic activities in school. The physical disability does not prevent them from learning unless other severe disabilities are also present.

Disability characteristics. Impairment interferes either permanently or temporarily, with the normal functioning of the nerves, joints, muscles, or limbs.

Causes. Genetic abnormalities result in individuals being born with a club foot or with missing limbs. Some are caused by diseases such as polio or bone

tuberculosis. Maternal infections during pregnancy are known causes of forms of cerebral palsy. Alcohol and drug use by mothers may lead to fetal abnormalities. Still others are caused by accidents leading to amputation or injury to the spinal cord.

Ability potentials.

1. Ability to learn. Some physical impairments may not be related to impaired brain functioning. So those with this disability may perform well in school except in activities involving much physical effort. Cases of underachievement exist when psychosocial needs are not met resulting in poor self-concept. Some cases of cerebral palsy have problems in brain development leading to intellectual disability.
2. Ability to physically perform and/or work. Depending on the severity of the impairment, some individuals are able to work provided they have some means of mobility (e.g., wheelchairs). Those with rheumatoid arthritis may be in constant pain. They may also get tired easily. Others who have muscle dystrophy may not be able to work.
3. Ability to take care of oneself. Some need lifelong support. Others with less severe conditions may be trained to do personal grooming and dressing, food preparation, and other self-care tasks.
4. Ability to relate with other people. Communication may be difficult for those with cerebral palsy. Physical interactions such as playing and dancing with other individuals may be limited due to mobility problems. In a lot of cases though, there should be no impediments to building relationships except society's attitudinal barriers towards those with disabilities.

Special health problems

Disability characteristics. The disability is related to health conditions that tend to keep children and youth out of school. They persist for a long time and may even lead to death for some individuals. Illnesses like heart diseases, diabetes, tuberculosis, asthma and other respiratory ailments, carcinoma, allergy, epilepsy, and other seizure disorders, and AIDS are some health problems they tend to suffer.

Causes. Some health impairments are hereditary such as heart diseases and asthma. Other causes are brain injuries before or during birth such as in some seizure disorders, environmental toxins and allergens, and infection due to tuberculosis and AIDS.

Ability potentials.

1. Ability to learn. They may have poor attention and memory retention because of the drugs they have to take. They may also be slow in learning concepts, knowledge and skills. Otherwise, their capacity to learn is unhampered.

2. Ability to physically perform and/work. They have decreased stamina and endurance. They usually miss classes due to health reasons.

3. Ability to take care of oneself. Some individuals are capable of administering their own medicine but others may need a lot of assistance especially in school. They also need to be assisted or supervised in their dietary restrictions and work/academic load.

4. Ability to relate with other people. The nature of some diseases, specifically those that are infectious, limits face-to-face contact. Stress and anxiety about their health condition strain some relationships. Their situation may also lead to dependence on other people.

Children and youth with cognitive-processing and behavior-related problems/disorders

Autism

Franco is a five-year old boy diagnosed with autism. He prefers playing alone. He lines up his toys and insists following routines. He does not look at the person eye to eye whenever he is talking. He cannot express what he wants. When hungry, he would not say anything but just throw tantrums.

Autism is receiving the most attention these past few decades because of the sudden increase of the number of children diagnosed with autism. Advances in medical technology and psychological research here and abroad have led to improvements in assessing or identifying those with autism.

Disability characteristics. Early description of the condition cites the seeming withdrawal of the child into his/her own world, hence the term "autism," which came from the Greek word "*autos*" or "self." Autism is a lifelong developmental disability, usually evident after two years of age. Children "lose" the ability to speak after showing initial signs of language development. They have difficulty relating with persons, engage in stereotypic or atypical behaviors, and get obsessed with sameness: food, toys, routine, arrangements of things and TV programs.

Autism is five times more prevalent among males than females. It runs across race and socio-economic levels. It is also eight percent more likely to occur among siblings. Recent estimation pegs that one out of 150 children has some form of autism.

Autism appears in several forms. What is now called autism spectrum disorder (ASD) was previously pervasive developmental disorder (PDD). Autistic disorder (classic autism) and Asperger syndrome (high functional autism) are the most prevalent.

Causes. Autism is an organic brain disorder. Despite recent advances in the study of autism, there is no clear-cut single attribution for its cause. The

emotional cause due to cold and distancing parenting ("refrigerator moms") has been ruled out. The neurological and genetic bases for its occurrence are strong however. Brain images of children with autism reveal that there are certain structures in the brain that are either very well developed or lacking. Genetic abnormalities are also implicated as one cause of autism just as in other forms of intellectual disability. It has not also been proven that autism is caused by certain vaccines administered during early childhood to prevent measles. Although several food regimens are being endorsed by some groups (gluten-free, casein-free diet), scientific research has not shown that children with autism fed with this diet eventually lost their characteristic behavior (Elder, J.H., et al., 2006). Early intervention, however, can help manage certain behaviors and enable children to cope with their disability.

Ability potentials.

1. Ability to learn. About 70 percent of children with classic autism have moderate to severe intellectual disability. Academic performance is below those of their peers. They have problems in concentration and attention. They focus on details without seeing the overall picture. Hyperactivity is fairly common. Many have abnormal responses to sensory stimuli such as hypersensitivity to light and colors, sounds, or touch. Some are able to endure high levels of pain that is why they appear not to be hurt when they resort to self-injurious behaviors. They show repetitive behaviors such as arm- or hand-flapping, rocking, and spinning. They suffer from several communication deficits. Some lack spoken language. Echolalia or repetition of words present most often in very young regular children persists into older age. They are preoccupied with sameness of activities and following routines that when disrupted may resort to tantrums.

Those with Asperger syndrome do not typically have intellectual disability. Some have been assessed to have above average mental ability, such that they may be able to earn college degrees when given opportunities. Cases of hyperlexia, or precocious ability to read and memorize (with marked comprehension delays) prior to formal instruction are known to occur. They are highly verbal but lack conversation skills. They also have repetitive behaviors and fixations or perseverations on specific things, tasks, dialogues, sights or routines.

2. Ability to physically perform and/or work. Some children with ASD have problems with their digestive system. Allergy for some food has led some families to resort to gluten-free diet. They also have irregular patterns of sleep. This does not affect much the quality of their work however. They are able to work well especially those who require routine activities.

3. Ability to take care of oneself. They can be taught basic functional skills. A majority with autism will never be able to live independently from adults. Those who do may still need constant supervision and monitoring.

4. Ability to relate well with other people. The main areas of concern for children and youth with ASD are their communication and social skills. Because some are not able to develop speech, they are constantly dependent on communication acts. But even for those who can speak, they are still not able to sustain long-term relationships because o their lack of interest in other people. They are not sensitive to feelings and frequently cannot read expressions. They bond more with objects. Their areas of interest are pretty limited, that is why their conversational skills are deficient. Still, these do not

restrict them to enjoy their activities throughout life, to contribute productively to society and even live peacefully with other members in their own community.

Attention-Deficit and Hyperactivity Disorder (ADHD)

Disability characteristics. ADHD is a condition wherein the child or youth has difficulty getting focused on tasks and displays excessive movement. Children with ADHD usually have average mental ability. It is more common among boys than girls. The condition also co-exist with learning disabilities and emotional-behavioral disorders.

Causes. There are some signs that the condition is hereditary. Generally, it is believed that children with ADHD have structural or functional damage in the brain.

Ability potentials.

1. Ability to learn. Children with ADHD are expected to be able to learn. They encounter a lot of academic problems, however, because of their behavior. Their primary difficulty is maintaining attention. They seem not to be listening and are always distracted by activities or objects around them. With their tendency to be careless with their work, they usually commit errors resulting in poor academic performance. On the other hand, they enjoy receiving rewards.
2. Ability to physically perform and/work. Their difficulty of completing assigned duties makes them inconsistent in performance. Their problems of remembering information leads to an inability to follow a series o tasks. They are also not time-conscious and not concerned with order.
3. Ability to take care of oneself. They may find it hard to do self-care tasks and tasks involving health and safety.
4. Ability to relate with other people. They have a few friends because they lack appropriate social skills. They talk a lot and tend to

monopolize conversations. They appear tactless and are not much concerned about the feelings of others. They sometimes initiate quarrels (*palaaway/palengkera*) because their behaviors irritate others, and may not be good team players.

Behavior problems

There are different kinds of behavior problems depending on the child's family and childhood environment (Smith, 2007). Take the case of Aries who often hits his classmates. Sometimes, he does it just for fun. He never stops until his classmate cries. Even if his teachers have given him warnings or some forms of punishment, he still continues hitting his classmates.

Caloy, a 16-year-old in the youth center, has gone through problems in his life. He has been in the center for two years now. His father lost his job and could not support the family anymore. His mother, a cancer patient, died because the family could not afford the treatment cost. His brothers and sisters have all stopped from schooling. He was sent to the center for these reasons.

Caloy did not like life in the center. Thus, he was not able to adjust to his new circumstances. Lately, he has become sad upon learning that his father died in an accident. He would be found staring blankly at the window. His movements have become slow. Center personnel have to force him to eat, to take a bath, and to interact with peers.

Melissa, a 14-year old, suffered from sexual abuse. In the youth center, she wakes up in the middle of the night shaking in fear. She does not want to talk to people, is not interested to take care of herself, and often has a blank look as if she were daydreaming. It has already been a year since Melissa has been behaving this way.

Jaime, a 15-year old, has a lot of mood swings. In the morning, he may be very happy. Sometime at noon, he feels sad. His moods change so often that the other children in their shelter do not want him to be their friend.

All the above examples of Aries, Caloy, Melissa, and Jaime show children and youth with behavior problems. Some other children may exhibit aggression. Some may have different kinds of moods during the day. Some feel very sad. Others may experience physical symptoms of anxiety such as shaking in fear or having a "racing pulse" (a fast pulse beat).

Disability characteristics. Children and youth with behavior problems are those who cannot adjust to socially-accepted norms of behavior. As a result, they are not able to sustain harmonious relationships with peers as well as with other people. They also perform poorly in school. Their emotional state or social situation requires providing instruction outside the regular class. Children with behavior problems include:

1. The socially maladjusted. They are aggressive and willfully disobey authorities. They follow their own rules and repeatedly violate social and moral conventions. Some children in conflict with the law belong to this category.

   Children in conflict with the law

   These are children who have committed crimes at a very early age. Their offenses range from petty theft, snatching, injuring someone physically, to major ones like drug pushing, rape, murder, and homicide.

   When asked for reasons why they committed these crimes, the children who were staying in the centers replied that they did not have the intention to do such things and live a criminal's life. They said they were only forced to snatch cellphones and jewelry because of poverty, or because they have to buy medicine for their sick parent or relative besides having nothing to eat at home. Circumstances such as these have forced them to commit crimes including harming other people.

2. The emotionally disturbed. These are children and youth who have no mental illness and yet are not able to function well in school and other settings for a long period of time due to emotional problems or difficult circumstances. They either become withdrawn and depressive or become hostile towards others.

3. Children in especially difficult circumstances. These are children including street children who are abandoned, neglected, and abused whether physically or sexually. They may be left on their own and live in the streets or taken custody by institutions. They may or may not manifest behavior problems.

Street children

These children are found roaming around and making their living by begging in the crowded streets and roads in big cities where the urban poor sector constitutes a large sector of the city population. They come from the slums or squatter areas. Their parents are often jobless or may have only irregular jobs that cannot sustain the daily food needs of a large family. They appear dirty, wearing tattered clothes and old slippers.

They beg for a few coins in sidewalks, knock on windows of cars or get inside public utility jeepneys to ask for money from passengers, or enter inside restaurants to beg for leftover food. To get the attention and sympathy of people, they carry a baby with them as they roam and beg around.

In the streets, they meet and join other street children who inhale rugby, a toxic substance that is used in the manufacture of epoxy glue. They may have taken a liking to inhale the substance because their friends are also doing it. They also do it because it makes them feel happy. It changes their mood and makes them forget their hunger for food. Their problems disappear the moment they smell rugby. A

tablespoon of rugby placed in a small plastic bag makes them "high." To inhale rugby enables them to escape from a life full of unhappiness.

Other street children become victims of child prostitution. Parents are reported to have served as pimps or agents in the transaction between their children and the customer, usually a foreigner who can pay dollars. Prostitution is illegal in the Philippines but street children have their protectors.

Street children expose themselves to health risks as they beg and roam around in the polluted streets of the city. They may eat unsanitary food that they find in the garbage. Sleeping in sidewalks may infect them with skin diseases while lack of sleep slowly weaken their resistance to such diseases as tuberculosis. They are also exposed to respiratory diseases because they always breathe polluted air emitted by vehicles.

Finally, the kind of life lived by children in slums affects them emotionally. While they may have been initially sent to grade school by their parents, their problems and lack of proper nourishment at home make them poor school performers. In the end, they drop out of school. Once out of school, they drift into the streets with other children with similar experiences, and the cycle of begging and roaming around the streets follows after.

Causes. Biological or genetic factors and environmental factors lead to behavior problems. Alcohol, cigarette and drug use affect certain brain functions and, therefore, contribute to emotional or behavior disorders. Lead poisoning and exposure to other toxins can also alter behavior. Absence of secure and nurturing family results in behavior problems, too. Poverty is a primary risk factor to the development of behavior disorder.

Ability potentials.

1. Ability to learn. More often than not, they have low to average mental ability. Their poor academic performance is usually the result of absenteeism. They are also poorly motivated and, thus, later quit school. Some have mild forms of intellectual disability while others may have learning disabilities. Some may show language delays.

2. Ability to physically perform and/or work. They are poorly motivated to work and seem to lack the energy to do so.

3. Ability to take care of oneself. Depressed children and youth tend to neglect personal care and safety. They sometimes resort to substance abuse or, worse, to get self-injurious.

4. Ability to relate with other people. They have difficulty building and maintaining healthy relationships with peers and adults because they are usually a product of families with unhealthy or dysfunctional relationships. This is compounded by aggressive behaviors. They also exhibit immaturity in relating with other people.

Other children with special needs in the Philippine context

Unlike in western and developed countries, the Philippines also include children at-risk or in difficult circumstances. These children who can be potentially labeled as CSN include the following:

1. Children in areas where there is armed fighting between government soldiers and rebel groups

Armed fighting occurs in areas where there are rebels who want to replace and take over the formal government of the Republic of the Philippines, or who want to break away or secede from the territory of the Philippines and form their own independent country. In these areas, not only the government

soldiers or the rebels suffer and lose their lives, the civilians caught in between the fighting also suffer due to fear, constant evacuation, displacement, and loss of life and property.

Children who are in these areas are witness to brutal deaths and violent tortures. They feel the pain of physical injuries and emotional separation. The trauma, the danger that anytime bullets or bombs may hit them, cause severe emotional stress that lead to behavioral problems.

Children in these areas may eventually results in having special needs. Thus, they also need special education for them to maintain their emotional stability and keep strong and courageous in pursuing their life plans and goals.

2. Disadvantaged children including child laborers and those belonging to minority groups in extreme poverty and neglect.

Extreme poverty conditions force young children to become child laborers. Philippine laws prohibit child laborers but sometimes, parents have no choice but to have their young children work in order to earn a living. These children illegally work in factories, sell goods on the streets, work in mining and quarrying sites, and work as pearl divers as in the case of muro-amis. They are exposed to many environmental hazards such as pollutants and toxins. They can get sick while working.

Children coming from ethnic minority groups are also disadvantaged. These ethnic minorities under extreme poverty conditions and lack resources. They may live in places that have non-arable land, hence, getting sources of food may become a problem. Some of them live in places that are far from bodies of water, and this results to hygiene problems. There may be absence of lavatories and facilities that are needed in maintaining hygiene. Their parents may neglect their obligation to care for them and they may be forced to beg for alms in urban areas in order for them to earn a living.

These children are at risk of disability. Poverty conditions create a lot of hazards to them.

Conclusion

The concept of "children with special needs" or CSN in the west and rich countries differs from that in the Philippines or in poor countries. Added to the CSN category in the latter countries are street children, children who have committed crimes, and children located in areas of armed conflict. These additional CSN categories are generally not found in rich western countries.

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WHAT SPECIAL CHILDREN NEED

Myra Trinidad Timtiman-Tantengco

Introduction

Children with special needs (CSN) have necessities just like everybody else. Using Abraham Maslow's hierarchy of needs, their first basic necessities are **physiological needs**. These help them survive and include food, clothing, shelter, and medical attention. Next, they have **safety needs**. They need to know that they are out of danger. They also need to know and experience **love and acceptance** from their families, friends, classmates, and the community in which they live for them to have a feeling of safety.

Furthermore, CSN want to feel good about themselves and know that others respect and value them. These are **esteem needs**. Finally, they need **self-actualization**. They know what they are capable of doing and what they want to be. They need the chance to show what they can do and the opportunity to be the best that they can be.

Physiological needs

Providing for the safety needs of CSN includes giving them access to (1) newborn screening, (2) health care, (3) rehabilitation centers, (4) good nutrition, and (5) adequate shelter.

Newborn screening. Hospitals, lying-ins, rural health units and health centers provide newborn screening. These are a series of tests done on blood samples of infants to determine the presence of diseases or disorders that are not noticeable at birth, but require immediate medical attention. If not treated, these conditions can cause growth failure, negatively affect the development of the brain, and lead to permanent intellectual disability or seizures. Parents need

to be encouraged to have their babies screened so that health and developmental problem may be addressed as early as possible.

Health care. All around the world, children suffer, are disabled or die because of chicken pox, diphtheria, hepatitis B, measles, mumps, pertussis, polio, rubella, and tetanus. Some parents, in the past, pointed to *kulam* or witchcraft or other superstitious beliefs as the cause of their children's diseases. To prevent the untimely death or disability of children, it is best that they be brought to the pediatrician for immunization and booster shots. Vaccines build resistance in children against diseases so that when a confirmed infection happens, their bodies are better able to fight it.

A number of children with intellectual disabilities are born with conditions that require greater medical attention.

- Some babies with Down syndrome have a congenital heart condition (Medline Plus Medical Encyclopedia). They have a hole in the wall of the heart. The heart pumps too much blood to the lungs such that these children experience shortness of breath, fast or difficult breathing, and a very fast heartbeat. They have a pale color and may sweat while eating. They may also suffer from frequent respiratory infections. Babies with this condition need very close monitoring by a doctor to make sure that the hole closes and that heart failure does not occur. If symptoms of heart failure are observed, medication and surgery are required.
- A number of children with intellectual disabilities may have epilepsy, cerebral palsy or infections. They need medication. Others suffer from visual impairments, congenital vision loss, cataracts, and hearing impairments. These children need to receive regular eye and ear check-ups from doctors so that their seeing and hearing needs can be met.

- The inability or difficult time children with intellectual disability have in taking care of themselves also makes them vulnerable to dental health problems. They need regular dental check-ups and services of a dentist familiar with intellectual disabilities.
- Persons with visual impairment require medical and special services, too. Those who are nearsighted, farsighted, or who have astigmatism need to be checked by an eye doctor to ensure that refraction errors are corrected. Check-ups must be regular. Be alert of complaints of *malabong paningin* (blurred vision) and difficulty in reading. Appropriate pairs of eyeglasses should be provided so that they can enjoy clear vision.
- Some children who are born prematurely experience abnormal development of blood vessels in their retina. These children's eyes may be crossed (*duling*), move abnormally (*malikot* or *banlag*), severely nearsighted, and have white-looking pupils. In severe cases, they may go blind. Babies in this situation require early treatment to increase the chances for them to see normally.
- Children with hearing impairment need hearing aids for their own safety and incidental hearing. With hearing aids, they will learn to communicate with their family and with others. As they grow older, communication skills are required in going to school, joining the workforce, or interacting with friends, classmates, teachers, superiors, and co-workers. To acquire these skills and to function properly, they require hearing aids.
- People with emotional and behavioral disorders need drugs prescribed by doctors to control behavior (Taylor, Smiley, & Richards, 2009). Parents and teachers have to provide feedback to medical professionals. Doctors need this information so that they can decide whether to continue, stop, or adjust the medication.

- Many individuals have physical or health disabilities. They were either born with those disabilities or have acquired them later in life. They require medical attention, paramedical assistance and medication. Children with cerebral palsy, for example, require medical help to deal with seizures, vision problems, hearing loss, and feeding problems. They also need the services of a physical therapist to meet their motor needs, as well as a speech therapist for their communication skills. Wheelchairs or walking devices allow them to move about independently.
- Persons with epilepsy also need medication to control their seizures. However, these drugs make the patient less alert. Any patient taking such medications must be closely monitored. Current practice suggests stopping medication after a two-year seizure-free period.
- Asthma is a common cause of breathing difficulty. This is triggered by viral infections, allergic substances, or by stress. Normally, asthma is treated by a means of medication called a bronchodilator. This relaxes the muscles around the airways. Substances such as dust, pollens and aerosol spray, and animal fur can start an asthma attack and, therefore, must be avoided.

Rehabilitation centers. Children with special needs require the services of qualified doctors and allied medical professionals who are familiar with persons with disabilities, their families, and with available community health and social services. The following are, therefore, necessary:

- *Funds.* The Department of Health (DOH) is directed to establish and provide funds for the operation of rehabilitation centers in government hospitals.
- *Rehabilitation services.* Children with special needs who cannot afford rehabilitation services can avail of these in the DOH-operated centers.

Good nutrition. Children with special needs require adequate nutritious food to survive and develop fully. In the centers, they are provided with good nutrition and balanced meals. They require food for them to enjoy a healthy life. Some, however, need a unique diet for their own health and to control unusual behaviors. For example, children with Attention Deficit/Hyperactivity Disorder (AD/HD) are very sensitive to sugar and stimulants such as soft drinks, coffee, sugary cereals, fruit drinks with high sugar content, and chocolates.

Children with autism often need a combination of diet and vitamin and mineral supplements. They are usually provided a casein- and gluten-free diet. Casein and gluten are proteins found in dairy products, oats, and wheat. Vitamin supplements of A, B-12, C, and D are also given to improve eye contact, attention and behavior, and communication attempts. Cod-liver oil, a rich source of Vitamin A, is believed to improve the functioning of the brain of persons with autism.

The guidance of a pediatrician, a nutritionist or a dietician, is necessary. Parents and caregivers need to be careful of the food they prepare for CSN so that unusual behaviors can be lessened. These children should also be taught how to make healthy food choices.

Adequate shelter. Children with special needs staying in the centers are blessed to have a shelter. Many children, however, are abandoned (*pinabayaan*), or sent away (*pinalayas*) by their parents. Others left their abusive homes and have no other place to stay but in the streets. They earn a living in the streets during the day and sleep on cardboard boxes or in carts at night. These special children and youth need a warm and loving home where parents can nurture and give them guidance. When this is impossible, a loving foster home or residential institution can be an alternative.

Safety needs

People want to feel safe. They need to feel secure from the things that make them afraid or insecure, whether imagined or real. The same is true with CSN and their families. They need: (1) protection from ridicule, (2) protection from harm, (3) education and training programs, (4) dignified gainful employment, and (5) physical, emotional, and spiritual support.

Protection from ridicule. Children with special needs experience being bullied by others. They often become the victims of pranks, jeers and sneers. Those with physical deformities and mental delays are teased and called hurtful names such as *sintu-sinto* (stupid), *kulang-kulang* (lacking in mental abilities), *pilay* (lame), *bobo* (dumb), or *komang* (crooked arms) because of their physical characteristics or behaviors that set them apart from others.

Even the gifted are not free from bullies in school. In the same way that many children misunderstand their mentally-delayed peers, they tease and bully their gifted classmates for being "know-it-all" and *pasikat* (show-off) when, in fact, it is simply their nature to be smarter than average.

Children with special needs require the help of youth and adults who understand their pain and are willing to advocate for their right to be free from ridicule. They need people who can understand their condition and accept and respect them as human beings.

Some persons may take advantage of persons with intellectual disability. If some children bully them, others make them the scapegoat (*panakip-butas*) of their misdeeds when caught. It is, therefore, very important that CSN have adults who can monitor their relationships with other people. Children must be taught that bullying and name-calling are unacceptable. This will lessen negative situations from happening, and increase the possibility of positive and productive relationships with others.

Protection from harm. Many children and their families live in the streets because their homes were destroyed by fires, typhoons, floods, or demolition of urban shanty communities. Their lives are put in danger by street gangs, criminals, sex offenders, and rough police officers. They are also unprotected from the natural elements like the hot sun, torrential rains, or strong typhoons. Those in areas of armed conflict are constantly in fear of their lives when caught in the crossfire of military and rebel groups. Oftentimes, families are torn apart.

These special groups can benefit from policy makers, organizations and law enforcers who can advocate and work for their safety. They need government and non-government institutions that can offer the social services they require such as food, safe shelter, and care.

Education and training programs. One thing that makes a person's present and future uncertain is the inability to find employment. Without a well-paying job, persons with disabilities do not have the means to buy food and clothing. Neither will they be able to live independently. Instead, they will always have to rely on the generosity and charity of relatives and friends. This negatively affects how they perceive and feel about themselves – as a *pabigat* or burden to their families.

Thus, children with disabilities need appropriate special education and training which harnesses their strengths to maximize their potential. To enable them to find gainful employment, the need the following set of skills:

- *Literacy skills:* writing important details correctly, reading labels, directions, and street signs, performing arithmetic problems, comprehending and following instructions;
- *Communication skills:* effective listening, polite speaking, and positive body language;
- *Social skills:* behaving properly towards a client, making friends and getting along with co-workers, and conflict resolution;

- *Vocational skills:* filling out forms, sorting letters and packages, or talking over the phone; and
- *Life skills:* choosing the mode of transportation, problem-solving and crossing the street safely.

Dignified gainful employment. Although the Philippine government offers incentives to companies that employ persons with disabilities (PWD), only very few companies open their doors to them. Mainstream employment which offers good salary and benefits is still inaccessible to a majority of persons with disabilities despite their knowledge and skills. The following are, therefore, very important:

- *Change in the way PWDs are seen.* Private companies and corporations need to see them as important human resources and allow them to become productive and responsible citizens of the country.

- *Information dissemination.* Owners of industries and companies need to be informed of the incentives given employers of PWDs according to the Magna Carta for Disabled Persons:
    - "an additional deduction, from their gross income, equivalent to 25 percent of the total amount paid as salaries and wages to disabled persons" (Section 8b),
    - "an additional deduction from their net taxable income, equivalent to 50 percent of the direct costs of the improvements or modifications" on physical facilities (Section 8c).

- *Sheltered workshops.* Numerous PWDs choose to work in sheltered workshops in which they are given the chance for training and employment in a supportive environment. Work, however, is inconsistent because it depends on the availability of contracts and

supplies. Wages are low, working conditions are not ideal, and the possibility of exploitation of PWDs is present (Favis, 2002).

Physical, emotional and spiritual support. Children with special needs, their parents and significant others feel uncertain of the near or distant future. Children with cancer, for example, may be anxious about chemotherapy and its side effects. Not knowing if the treatment is effectively destroying the cancer cells can sometimes make them even more insecure. Parents try to shield their children from the painful truth by keeping their sick children in the dark.

Persons fighting life-threatening diseases may be aware of their condition and the effects of the procedures and medication they take. They also need physical, emotional, and spiritual support as they go through their ordeal. They need to be surrounded by cheerful and optimistic people who can lift up their sagging spirits.

Love and belonging needs

Children with special needs want to feel loved and accepted by their family, friends, and society. They need to be protected, guided and prepared to function well and productively in their community. What are important in addressing CSN's need for love and belonging? These are: (1) loving and caring family and significant others, (2) protection from discrimination, (3) access to quality education, (4) accessibility, and (5) adaptive equipment.

Loving and caring family and significant others. Every child is born to a family. It is his family that nurtures and nourishes him. Children with special needs must have a family that loves and accepts them despite their disabilities and unique needs (Dizon, 2010).

Sometimes some families cannot be relied on to provide what these children need. It is here that government and non-government agencies must

step in to provide those needs through residential or foster care. Children with special needs require a family or significant others for the following reasons:

- By recognizing, accepting, and understanding them, they help CSN grow and develop into the best that they can be.
- Children with special needs are vulnerable. The family and significant others can protect them from harm and abuse, and can advocate for their welfare.
- Children with special needs will benefit when the people who raise them believe in them and their abilities, and do not give up when raising and teaching them become difficult.
- Family and significant others who are willing to spend quality time with them are beneficial to CSN. These children require people who can listen to their needs and stories, to their victories and joys in life, their failures, fears, and sadness, and respond with understanding, lend an ear to them, and believe with them that they can reach their dreams.

Protection from discrimination. A loving, accepting environment benefits the CSN. According to Article 2 of the United Nations Convention on the Rights of the Child (UNCRC, 1990), children should be protected from all types of discrimination based on their or their parents or legal guardians' race, skin color, sex, language, or religion. They should not be separated or excluded by their political or other opinion, nationality, ethnicity or social origin, property, disability, birth, or other status. That means that they cannot be excluded from enjoying what other children have just because they are different from them.

Access to quality education. Learners with special needs require quality education that will equip them with knowledge and skill and prepare them for a dignified and productive life. Access includes the following:

- *Psychoeducational assessment.* The learner's characteristics, strengths and weaknesses will point out how to meet his educational needs. It

requires a physical examination and a development history of the child. A series of academic, intellectual, adaptive, and socio-emotional tests are given. Observations are conducted and parents, teachers, and caregivers are interviewed for more information. The assessment provides adequate information on how the child learns, his level of performance, strengths, and possible areas of need.

- *Individualized educational plan.* An educational plan especially made for the special child considers his educational needs, strengths, and weaknesses based on assessment results. It specifies the accommodations and modifications necessary for the learner. Some learners with special needs will benefit from a highly individualized educational program if their learning needs cannot be met by the regular educational system.
- *Special education.* Special education provides the services of trained personnel who teach a curriculum particularly designed to meet the needs of the learner. These special teachers use unique teaching methods and materials in a modified environment. Related services like speech therapy, mobility training, and physical therapy may also be provided. There are many CSN, however, who can benefit from the regular educational system and learn with regular students by means of varying accommodations and modifications.
- *Adapted and distraction-free environment.* Children with special needs benefit from rearranged seating positions near classmates or teacher who can assist them. For them to focus on lessons, they must be seated away from trash cans, pencil sharpeners, open windows, and shelves which offer visual and auditory stimuli that distract them.
- *Accommodations.* These are services or supports to special students without changing what they learn and what they are expected to do or produce as evidence of learning. Accommodations range from Braille materials or large-print books for the visually impaired, and

tape-recorded books for those with reading disabilities, to study guides and visual aids for better understanding. Answering situations may not be strictly times and answers to tests may be given orally.

- *Modifications.* These are supports or services given which change what special students learn. Children with special needs may be taught less content or a different content altogether. They are also not expected to perform the same way regular students do.
- *Educational assistance.* Poor but deserving students require assistance such as scholarship grants, student loans, subsidies, and others.
- *Daily routines and schedules.* Children with special needs benefit from structure in what they do. They need clear schedules to guide them through tasks that should be accomplished.
- *Transition program.* Children with special needs require matched activities that prepare for changes throughout their lives. This is often used to refer to planning for life after high school, which includes: employment, postsecondary education, vocational training, continuing and adult education, adult services, independent living, and community participation (Palmer, Miles, Shierkolk, & Fallik, 2002, cited in Taylor et al, 2009). The activities must consider what the CSN, now a grown PWD, is interested in and likes, as well as his community experiences.

Accessibility. The Accessibility Law (Batas Pambansa 344, 1982) provides CSN a barrier-free environment for them to access facilities and attend important events as the non-disabled do. These include cut-out curbs and accessibility ramps, audiovisual aids to cross streets, elevators that allow maneuverability of wheelchairs, and handrails on both sides of ramps. It is best that toilet facilities have adequate turning space. Bold graphic signs must be placed in conspicuous areas. Parking slots for persons with disability should be near entrances or exits of buildings. Telephone units with visual aids must not only be accessible, but also reachable. Wheelchair-bound persons must be able

to reach switches and controls. Floor finishes should not be too slippery or hamper mobility. Public transportation and government-operated airlines and trains must provide seats for the disabled.

Adaptive equipment. These are specialized devices designed and used by many CSN to help them develop and function properly and participate in daily living activities.

- *Prostheses.* These are artificial devices which replace parts of the body that are missing from birth or due to traumatic injury (Encyclopedia Britannica, eb.com). They enable the CSN to be independent, to move freely, and to participate in walking or running. They are also important for appearance.
- *Orthoses.* These are external orthopedic appliances that either stop or help the movement of the spine or limbs (American Heritage Medical Dictionary, 2007). Examples are leg and back braces.

Taylor and his colleagues (2009) also suggest the following equipment for CSN:

- *Augmentative communication devices.* These devices help persons who have difficulty in communicating orally to express their thoughts. Picture boards contain pictures of basic things that the CSN need such as food, water, or toys. Meanwhile, symbol boards contain symbols such as a happy or sad face to indicate what a person feels.
- *Hearing aids.* These improve a person's ability to hear by increasing and changing sound.
- *Visual communication technologies.* These devices find a way around the need for hearing and presents information visually. Closed captioning presents spoken language along the bottom of the television screen so that it can be read). E-mail is a popular means of fast interaction and communication between persons through the Internet. Word processing helps students and their teachers in the

teaching-learning process with grammar and spelling errors checked and corrected. It allows a student to produce work with less errors.

Esteem needs

Everyone has a mental picture of him/herself. This is called self-image, which is based on one's experiences as well as dealings with others. This self-image plays a role in one's self-esteem. Children with special needs are at risk of having low self-esteem. They often see themselves as imperfect or "damaged goods" when they compare themselves with others. Sometimes, they hope to be someone they are not and fail to see the abilities they have. Many of them have a strong sense of failure because they rarely experience success.

Those with chronic illnesses are hindered from participating in strenuous activities with regular children. They are often absent from school and this can have negative effects on their academic performance. They may feel ashamed of their bad health.

Like everyone else, CSN need to feel good about themselves. To help them develop their self-esteem, service providers need to remember the following tips:

- *Think good thoughts about CSN.* Choose to see the things that they can do, instead of the things they cannot do. Focus on their abilities and talents, not on their disabilities and weaknesses. Believe that they can reach their highest potential.
- *Let them hear good thoughts about them.* Don't let them hear "*Hindi mo kaya 'yan*" (You can't do that). Let them hear instead, *Sige, subukan mo. Kaya mo iyan* (Try it. You can do it).
- *Stop being critical.* Nobody is perfect. Negative criticisms and insults discourage CSN. Give them praise for their achievements.

- *Provide new activities for them to enjoy and to experience fun.* Let them do things they love to do. Provide activities that tap their talents.
- *Listen to their opinions.* Children with special needs have so much to share. They may see things from a different point of view. Listen to them and value what they share.
- *Teach them the skills that will help them become an expert at something.* It may be an activity as simple as sorting eggs according to size to performing a song. Give praise to their performance and give them the opportunity to use their skills
- *Surround them with people who have a positive and uplifting attitude*. Positive people always see the bright side of things, and have something to be thankful for and happy about.
- *Provide them opportunities to help others.* When they contribute to making life better for others, they also feel significant and valuable.
- *Teach them to accept compliments graciously.* Teach CSN to politely accept praise and positive comments about their work, abilities, or talents.

Self-actualization

Every person wants to realize his full potential, to be fulfilled, to become everything what he is capable of becoming. Everyone wants to be someone and accomplish something worthy in their lives. Whether simple or grand, working towards that dream and finally reaching it brings joy and satisfaction. This feeling is also the same with CSN.

To give CSN opportunities for self-actualization, service providers need to remind themselves that these entail:

- Having access to appropriate education and training to get a well-paying job;

- Developing skills of the CSN for him to be more independent;
- Providing opportunities to practice decision-making;
- Leaning about oneself, learning strengths, likes, rights, and responsibilities;
- Acquiring appropriate social skills like requesting help and seeking explanation;
- Having work-related skills; and
- Thinking about and preparing them for the future (Mastropieri & Scruggs, 2000). The need to prepare for the future security and well-being of the PWD is of great importance (Dizon, 2010).

Conclusion

Children with special needs have various needs. These include physiological needs, safety needs, love and belonging needs, esteem needs, and self-actualization needs. What these mean in actual application by service providers to CSN were discussed and elaborated. Service providers must cater to their requirements to give them the opportunity to fulfill their potentials.

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THE CHILD WITH SPECIAL NEEDS AND HIS POTENTIALS

Lutze-Sol Aplaon-Vidal

Introduction

Mention an exceptional child, a special child, or a child with special needs (CSN), and right away, almost everybody thinks of and looks for that associated disabling condition. A child who does not talk yet at age four, or does not walk at age two, or does not play with other children at age five, almost always elicit from others the question, "what is it that is disabling the child?"

Indeed, CSN are first seen in what they cannot do, and less of what they can do. Children with special needs do have obvious limitations such that people tend to focus on them too much. Areas where these children can possible shine in and the children's efforts to compensate for the limitations are just taken for granted. Teachers, support-service givers, and especially families of CSN are often concerned with providing them their needs rather than looking for possibilities and the potentials of these children.

It is in this light that CSN be seen in a different angle, which is to see beyond their limitations and to bring about a world of possibilities for them. Special education teachers and service-providers play an important role as vehicles who can bring about the promised possibilities.

Preparing to accept the CSN as they are - their conditions and limitations - and then opening the mind to possibilities in all aspects of their growth and

development in life facilitate service-providers' goal of becoming committed and effective helpers.

Potentials of CSN

Children with special needs are not totally disabled of skills that regular children possess. If that is the case, what are their potentials?

Potentials are skills and behaviors that a person is capable of. The term is not synonymous, however, with achievement or aptitude which projects the idea of what the child has already achieved or done. *Potentials* relate to what a child can achieve. This means that these have not been developed or discovered yet. They are just waiting to be tapped, and unless tapped through interventions, they will not be developed or discovered.

Experts in special education attest that in their observations of CSN, a vast area of potentials and qualities are just waiting to be tapped. This survey of 174 respondents working in institutions/centers for CSN found that the majority agreed that CSN do have potentials as much as regular children do.

What better way then to tap these potentials than by first looking at some beliefs commonly held about CSN. Some of these are myths and some are half-truths. Their examination would be a first step to unlocking the potentials of CSN.

Beliefs about CSN

1. ***Masuwerte ang pamilyang may* special *na anak*** (The family with a special child is lucky). A child with special needs may bring luck and wealth to the family. Others claim that they won lotteries and earned millions in their businesses because they had a child with special needs.

Take the case of Mommy Emma. She has a nine-year-old boy with intellectual disabilities. She considers him as the family's "niño" (from "Sto. Niño" - the image of Jesus Christ as a child). She believes that the child is their lucky charm and so she makes sure that he is always safe, healthy, and happy, including carrying him around wherever she goes, feeding, dressing, bathing, and providing him with all the comforts that her son needs.

No study has proven yet that the statement above is true. It is, however, the perspective or attitude of the family that makes the difference. A family that considers the CSN as a burden to carry around will see how everything seems to be going the wrong way. Such a perspective leads to the family becoming uninspired and hopeless. The genuine acceptance of CSN allows a family to see the positive side. Consequently, this pushes everyone and everything towards success in whatever endeavor - a state which is the same as being lucky - especially in the Philippines.

2. **Children with special needs do not live long**. Not all of them do, but it should not be a cause for surprise when a person with Down Syndrome in his thirties or forties is seen pushing a grocery cart in the supermarket or a person with autism who looks much older queuing at a fastfood store.

Of course, there are CSN who are terminally ill due to debilitating and fatal diseases and their complications. Most other CSN have developmental disabilities caused by neurological, genetic, and/or environmental factors. These disabilities last the whole lifetime of the CSN who may reach old age. This is the main reason why significant

helpers of CSN should not just teach; they should intervene and help children reach their daily goals and prepare them for their future.

3. ***Tulungan mo kasi hindi niya kaya 'yan mag-isa. Kawawa naman*** **(**Help him. He can't do that by himself. Have pity on him). Children with special needs are often depicted as weak, dependent, unaware and ignorant (*walang alam*), and they usually become so as predicted by the labels. However, when their families and other significant persons/helpers give them the opportunities and support to learn and be trained for independence and self-reliance, they blossom into their full potentials – at times even more beautifully than their regular counterparts.

   Remember that deaf girl who graduated with honors in college? How about that person with autism who opened up the world of autism by describing herself and what she had been through? Remember the stories about countless persons with disabilities who could hold paintbrushes with their lips/toes, and those who could not see but could sing with angelic voices?

4. ***Bakit mo ilalagay sa*** **classroom** ***ng mga*** **normal** ***eh*** **special** ***nga 'yan?*** (Why put the CSN in a regular classroom when he is special?). For a long time, it has been believed that CSN should be segregated in self-contained SPED classes in SPED schools/centers. Recently, with the dynamism and brilliance of SPED, mainstreaming and inclusive placement programs now enable CSN to join their regular peers and have the same access to the opportunities they enjoy. This is why CSN are now more visible in regular classrooms. They may be supported by some services or persons in these classrooms but they, definitely, benefit from the set-up in more ways than one. Children with special needs improve (speak, learn, socialize, behave) faster and

better when they are with their peers in regular classrooms rather than when they are placed with children in the same circumstances.

5. ***Lumayo ka d'yan; nananakit 'yan*** (Stay away; he/she will hurt you). Many believe that CSN are inherently physically, aggressive and violent. Some CSN with emotional-behavioral disorders do, but these are usually: a) unintentional, and b) brought about by other deeper reasons such as seeking attention and the inability to communicate effectively. Children whose language-communication abilities are highly affected by autism, intellectual disabilities, and AD-HD, often express themselves physically (e.g., holding tightly, pinching, tapping, biting, and at times, kicking and hitting) in order that others pay attention to them and their needs. Training them to speak clearly and meaningfully, however, helps address these behavior disorders.

   On the other hand, CSN who cannot speak out and defend themselves against abuse and violence far outnumber those CSN who actually resort to such, intentionally or unintentionally.

6. **CSN cannot empathize with others**. For some CSN, this is true. Some CSN do lack awareness of persons, things and happenings around them. This makes them less sensitive or sometimes even uncaring (*dedma*) to other persons' feelings and opinions. Yet, CSN have the potential to learn a range of behaviors that indicate empathy towards others. Unlike their regular counterparts, though, they would need various strategies including modeling, simulations and rehearsals for them to learn these skills – from the simple one of hugging to the complicated one of comforting others during moments of pain and sorrow.

Many parents can attest that their greatest fear upon knowing/discovering that their child has autism is that their child might never learn to demonstrate his/her love for them, but such is proven wrong when they see their child with autism kiss and hug them as they arrive home. Such is the consequence of teaching and training him/her.

7. **Children with special needs are laughed at, made fun of, or bullied by his/her regular peers**. At times, because of their innocence, vulnerability/gullibility, and a high sense of trust and dependence on others, the CSN become the class clowns and laughing stocks of their regular peers. Worse, they get bullied/abused physically, emotionally, verbally and/or psychologically by discriminating peers and even adults.

   Many CSN have the ability to assert/defend themselves in various ways though. Often, however, this important potential gets neglected or taken for granted.

   It is often heard in the news that CSN (especially girls) are victims of physical abuse and/or molestation by others including relatives. This is sad because it is also these relatives who are expected to teach them to say "No" to abusers.

8. ***Walang trabahong makukuha 'yan*** (He/She can never get a job). If finding a job among those without disabilities is difficult, would it not be doubly difficult for a person with disabilities? The question seems irrelevant because the Philippines is not yet really that prepared to accept persons with disabilities in the mainstream work force, even after they have gone through and finished education and training.

Not being able to do as much as their abled counterparts do often sounds as a lame apology for non-acceptance of CSN as company employees. If ever they get employed, these are often in non-competitive, less-skilled jobs. Business companies cannot also be blamed for not employing them because in these times, every peso counts. It is hoped, however, that the rest of the business sector opens their eyes and hearts to consider what CSN can offer (loyalty, sincerity, hard work, integrity, passion) beyond merely bringing in financial gains and profits.

The experience of one hardware businessman who hired a person with special needs is an insight to remember. "*I took a chance on someone who did not know how to compute because I got tired of being robbed right under my nose. Now, after 10 years, I realize that I made the best decision ever. That person is still with me even after having taught him how to compute,*" he said.

9. **Children with special needs will never marry and have a family**. Again, this is a matter of perspective. There are many considerations that have to be taken into account, such as: the disability itself, the degree of the disability, the awareness and level of acceptance of the other person/s involved, and the various implications thereafter.

   In some countries, it is very important for persons with disabilities (PWDs) to be ensured the same rights as others. When a PWD decides to marry and raise a family, the first consideration is upholding that right. If doing so meets this requirement, then it is embraced wholeheartedly with the government even giving the financial, psychological, and other appropriate support needed.

In the Philippines, people are more conservative and may frown at the idea of a PWD marrying off and then suffering thereafter. A PWD, however, has the same rights as any other citizen. If only he/she get the needed support from people around him/her, and the government and the society as a whole, who are we not to consider that marrying and having a family are valid options for him/her?

10. ***Hanggang d'yan na lang 'yan*** (That's as far as he can go). Intelligence levels and behavioral concerns of CSN constitute obstacles to their academic performance and other activities that regular children are capable of, but the CSN can do many things when provided with the opportunities to do so. In fact, they have the greatest potential when it comes to tapping skills they can use instead of skills that they cannot do (what are called "compensatory skills"). A child with autism may not know how to talk but may be able to paint as good as Fernando Amorsolo. A child with intellectual disabilities might not know how to read but may be an excellent cook. A child may be blind and deaf but may dance beautifully.

"That's as far as he can go" is probably true from the angle people prefer to look at. The CSN can go beyond others' expectations and can show them that he/she can be more. This is an attitude most regular persons need to consider given their tendency to underestimate the potentials of CSN.

Guidelines for significant persons

Being in the frontline of care and service provision, significant persons/helpers need to remember the following guidelines:

1. Believe that the CSN can do much more than what others think they can. At the same time, take into account their limitations as this means being able to set realistic goals for them, and working towards and believing with all honesty that this can be achieved.
2. As much as possible, keep the CSN in school. The school - especially the regular school setting - is an effective venue for the CSN to learn skills/behaviors as well as to hone potentials. It is not only a place for learning cognitive/academic skills but it is also where the CSN gets to imitate and have the opportunity to exhibit appropriate psychosocial and language-communication skills and structures.
3. Emphasize the CSN's positive points to increase their self-confidence. They need this as they try to develop/hone their own potentials. In circumstances when they are not able to do certain things, care/service providers must talk and explain to them that children have different strengths and weaknesses. If one is not good in something, he can always shine in another.
4. Use interest in tapping potentials. Most CSN hesitate to try anything for fear of failing. Initially, make them comfortable by engaging them in activities of interest. If a child loves playing with dolls and has a good singing voice but is shy, the service providers may play pretend and include singing with "putting dolls to sleep." This way, the child gets to hone her talent in singing alongside increasing self-confidence without forcing him/her to do anything.
5. Provide the necessary tools/devices, resources, and strategies to make it easier for CSN to learn a skill, exhibit a behavior, or demonstrate a talent. Children with special needs do not need to learn or to read musical notes to play the piano well. In learning to use the calculator,

the aim is to sum up the total grocery items and to make sure that the grocery list is completed and not mainly to compute non-purposively.

6. Provide opportunities for developing potential skills and talents without tiring the CSN. Tapping potentials is not merely asking them to do more or do something else. It also involves providing opportunities for CSN to master the skill/talent and apply it in practical situations whenever needed. That is the true measure that a skill/talent has been tapped.
7. Always support the CSN's efforts using positive reinforcements. Extra privileges and favors may be given on scheduled times to inspire them to do their best. Avoid punishment when they do not perform well. Or else, they get disappointed or traumatized and decide not to perform at all. If this happens, the CSN may not reach their potential.
8. Teach the CSN to accept defeat graciously. There may be times when despite several tries and the use of varied strategies, goals are still not reached. As helpers, the CSN need to be taught how to accept failure and to redirect them to other things that they can do so as not to make them feel bad about it.
9. Keep the CSN happy. It is the happiness, comfort and safety of the CSN that helpers need to have in mind before the wishes of the helpers themselves. Anything that impedes these three considerations must be put to a stop to give the CSN all the chances to reach their potentials.
10. Advocate. Significant persons/helpers need to advocate to those who do not know or know less about CSN by informing/educating them and changing their views about the CSN with the hope that they would be able to understand and by their own selves provide opportunities for CSN in an even larger scale.

Conclusion

It is wise to end this lesson by citing the analogy used by Dr. Edilberto Dizon, a SPED diagnostician, professor and counselor, in viewing the potentials of CSN. Dr. Dizon's "analogy of the cups" tells of a regular child who is endowed with a bigger cup of potentials and a CSN gifted with but a small cup. The regular child will most likely be able to fill his/her cup fully and fast. Small as the cup may be, the CSN might not be able to fill it as fast and at times, not even as full to its brim. With the help of significant persons, however, his small cup may be filled with everything that the CSN needs and can be happy about.

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PREPARING SERVICE-PROVIDERS FOR THE INTERVENTION OF CHILDREN WITH SPECIAL NEEDS

Marie Therese A.P. Bustos

Introduction

The community of nations across the globe, including the Philippines, has committed to mainstream persons with disabilities into society. It is because a disability is no longer to be hidden but should be addressed by families, barangays, schools, the industry, government and non-government organizations. With such impetus, the possibility of encountering persons with disabilities in any line of work is high. Service providers are no exception. Preparing them to work with children with special needs will be beneficial not only to their clients but to their institutions as well.

Who are these service-providers (SP)?

As disability becomes a community concern, many professionals and paraprofessionals become part of the human-service force for children with special needs (CSN). They can be house parents, psychologists, medical doctors, and dentists in residential facilities. They can also be day-care workers, social workers, teachers and teacher-aides, volunteer caregivers, rural-health midwives, community-health workers, barangay nutrition scholars, child-development workers, physical/occupational and speech therapists, and family care providers (Republic Act 8980).

What are the basic tasks and responsibilities of service-providers?

Service-providers work to ensure that CSN will be able to fully enjoy their human rights and actively participate in society. The core tasks are to:

1. *Recognize and respect the inherent equality and dignity of children and youth with special needs.* Any work with CSN begins with a deep respect for human life regardless of one's ability or disability. Philippine laws such as the Philippine Constitution, Republic Act 7277 and 9442 and international conventions such as the UN Convention on the Rights of Persons with Disabilities require equal enjoyment of human rights for those with disabilities.
2. *Advocate for the welfare of CSN.* To advocate means to strongly support and intercede. This is especially needed to ensure that persons with disabilities will be able to enjoy their rights and find their rightful place in society.
3. *Interact effectively with CSN, individually and collectively, and with other SP.* Work with CSN is almost always a collaborative activity. SP work together to design plans, implement strategies and evaluate programs. Not only do they have to be able to interact effectively with co-workers, they need to be able to work effectively with their clients who have special needs. Being able to understand human behavior (even maladaptive behavior) and adjusting one's style of relating to clients are crucial.
4. *Teach values, problem solving skills, and activities of daily living.* Successful integration of CSN into society depends on their ability to manage their personal lives and solve common daily problems based on a sound value system. Service-providers may perform this task in formal and informal settings. Teaching may be planned and organized or may also be incidental.

5. *Observe ethical practices.* Different SP are bound by the ethics of their profession. Appropriate conduct towards clients and colleagues is expected of them (Bustos, 2008).

Seasoned special education practitioners have identified professional dispositions or personal characteristics that enable one to work successfully with CSN.

What personal qualities make an effective service-provider?

Effective service providers (SP) are a personable group of people. A study on important qualities of special education practitioners indicated that SP are *easy to work with and have respect for colleagues and the children* in their care. They are *person-centered, patient, and compassionate* (Bustos, 2008).

Working with CSN is not easy. Many times, even seasoned practitioners do not know what to do. Hence, it is important that SP be *open and be willing to learn*. They should be *alert, analytical, and systematic*. To be able to do their job effectively, they are also *flexible and resourceful*, especially given the limited resources allotted for this population sector. When working with professionals who deal with children and youth, they are expected to *cooperate, collaborate, and to be collegial*. Teamwork is important. Lastly, effective SP *think and feel responsible for CSN* in their care. To them, it is more than a job; it is a calling, a vocation that life has called them to do. Because of this, they pursue excellence in their line of work.

Dizon (1982) and Quijano (2012) cite therapeutic-relationship values as crucial to the practice of service providers working with CSN. These values refer to *caring, empathy, selflessness and tolerance*. When SP are concerned about the welfare of CSN, wanting to help them and loving them unconditionally, they are able to touch and heal CSN's lives, empowering them to fully participate in society. This is what it means to *care*.

Caring is further enriched by one's ability to empathize or to put oneself in the place of another person. Empathizing helps an SP to understand CSN's behavior and helps build tolerance which results in one's ability to keep one's cool during trying times, especially when one is annoyed or frustrated with the CSN's response to intervention.

In summary, the qualities of successful SP can be encapsulated in the character of selflessness. Work with CSN demands much from the SP. Only a soul that has learned to forego comfort for the sake of creating good in CSN finds joy in its truest sense.

What information do all effective SP need to know?

The **core knowledge areas** needed to be able to work efficiently with CSN are:

1. Nature, characteristics of CSN
2. Nature of health conditions related to disability,
3. Legislation related to CSN,
4. Filipino values,
5. Best practices in teaching CSN, and
6. Knowledge of oneself in relation to CSN, co-workers and God.

What skills should SP have?

Core skill areas that SP should develop include:

1. Advocating for CSN,
2. Performing and teaching activities of daily living,
3. Analyzing tasks and behavior of CSN,
4. Managing behavior of CSN, and
5. Communicating effectively.

Much work concerning CSN will require *task analysis, behavior management, and effective communication with parents and professionals*.

What do SP need to know about task analysis?

When confronted with a child with special needs who has to learn problem-solving skills or activities of daily living, the SP may not necessarily know what to do and where to even begin with. Task analysis helps the SP to break down difficult tasks to simpler tasks so that the child can learn them easily. The important steps in task analysis are:

1. Identify the task that you want the CSN to learn,
2. Do the task yourself,
3. Write down the steps,
4. Observe others do the same task,
5. Watch the CSN perform the task, and
6. Adjust the steps in your task analysis to match the child's ability to perform the skill.

Regardless of the CSN's functioning level, he needs to participate in performing the task. Sometimes, it may seem easier and faster for the SP to do everything for the child. However, the child has to participate even partially in whatever task he should be learning.

How will SP teach the child important tasks?

Once the SP has completed the task analysis, he can begin teaching the child the steps to be able to perform the task. **Chaining** is the sequential teaching of steps to the CSN, one at a time. Mastery of a sub-task is required before teaching the next sub-task. If the SP teaches the first sub-task of the sequence and moves forward through the chain of sub-tasks as each is mastered, this type of chaining is called **forward chaining.** If the SP teaches the last sub-task and moves backward through the chain of sub-tasks as each is mastered, this is called **backward chaining**. If all the steps are taught and the

SP assists and prompts the child at every step, this type of chaining is called **total chaining**.

What follows is a sample task analysis for brushing the teeth. Note that each step has been identified.

1. Pick up the toothbrush.
2. Wet the brush.
3. Flip the cap of the toothpaste tube.
4. Put paste on the brush.
5. Brush the outside of the bottom row of teeth.
6. Brush the outside of the top row of teeth.
7. Brush the biting surface of the top row of teeth.
8. Brush the biting surface of the bottom row of teeth.
9. Brush the inside surface of the bottom row of teeth.
10. Brush the inside surface of the top row of teeth.
11. Brush the tongue.
12. Brush the inner cheeks.
13. Spit.
14. Wash the brush.
15. Replace the brush in the holder.
16. Grasp cup.
17. Fill cup with water.
18. Rinse teeth with water.
19. Spit.
20. Replace cup in holder.
21. Wipe mouth.
22. Flip cap back to cover the toothpaste tube.

Depending on the child's level of functioning, the number of steps in the task analysis may be reduced. Using the steps identified above, teaching from Step 1 onwards is called **forward chaining**. Teaching the child sub-skills beginning from Step 22 backwards comprises **backward chaining**. Guiding the child through all the steps is **total chaining**.

Reserve backward chaining for tasks that are quite difficult to perform, such as wearing of shoes or socks. This is to prevent frustrating the child too much. Doing the last step successful gives the child a feeling of success.

SP often face the challenge of dealing with problem behaviors of CSN. Successful work with them entails understanding and managing their behavior.

What does the SP need to know about behavior?

To be able to understand human behavior, it is important to realize four important principles (Boutot, 2008):

1. *Behavior is learned*. People do things because they have learned them. This can be things as simple as scratching one's head to one that is very complex, such as solving an algebra problem.
2. *Behavior serves a purpose*. People do things for a reason. Twirling pens, though seemingly useless, serves an entertaining value. Going to work each day to earn money means to support one's family. There is always a purpose for the things people do.
3. *Behavior has a context*. To understand behavior, the situation where the behavior was observed must be known. In the example of pen twirling, this may have happened during the lecture of a boring teacher.
4. *Behavior change is called learning*. A person has learned if he changes his behavior. Behavior change can be positive or negative. A child who imitates his parent he saw throwing garbage in the streets has learned. In the same way, people also consider that a child has learned when he respects his elders after being taught by his teacher.

What are the types of problem behaviors?

Behavior can be classified as ***destructive, disruptive,*** *and* ***distracting*** (Janney & Snell, 2000). *Destructive behavior* can be threats to one's life or property. Destructive behavior may include biting oneself, hitting a classmate, destroying furniture, and so on. *Disruptive behaviors* affect the smooth flow of daily routines. A child who runs away during class has to be managed by the teacher. The teacher, who is supposed to handle the entire class, leaves it and runs after the child. It is a disruption when lessons stop because the behavior has to be addressed. *Distracting behaviors* are seemingly useless, strange behaviors that prevent children and youth from successfully integrating into society. Echolalia or repeating what was heard, hand flapping, drooling, and so on, are distracting.

Why do children commit problem behaviors?

Almost all problem behaviors have reasons. Some serve a *social communicative intent*, such as getting attention, escaping or avoiding people or activities or getting something tangible that they want. Others have a *sensory function*. Children and youth do such behaviors because they are self-reinforcing and are rewarding for their own sake. Some of these behaviors are for play and entertainment, while others are for self-regulation or energy regulation, such as hand flapping, finger tapping, or spinning objects. Some behaviors have positive or negative intentions. Some behaviors may be expressed positively while others are expressed negatively. Sometimes the intention is positive but it is expressed negatively. Service-providers have to be open-minded and slow-to-anger to avoid misinterpreting and overreacting to seemingly negative behavior.

How can problem behaviors be managed?

The following steps can help the SP manage behaviors of CSN:

1. *Identify the problem behavior.* Instead of giving labels such as "playful," "*makulit*," "rude," and so on, the SP should only cite observable behavior and avoid labels and judgments. Decide if the behavior is destructive, disruptive, or distracting. Destructive behavior has to be addressed first.
2. *Gather information about the child's history and quality of life.* Check the records of the child. Interview him and ask significant adults about his background.
3. *Analyze the problem behavior.* The SP has to find out the events that lead to the behavior. What people, places, thing or activities predict the occurrence of the behavior? The SP must also describe the problem behavior itself. How often or how long does it occur, and how intense is it? Lastly, the events that follow the behavior have to be examined. What happens after the behavior?
4. *Develop a hypothesis about the purpose and context of the problem behavior.* The SP needs to ask: "Why does the child keep on doing it?" "What is the purpose of the behavior?" "What triggers the behavior and what consequences reinforce the behavior?"
5. *Create a plan that addresses the triggers, the behavior itself, and the consequences that reinforce the behavior.* Based on some hypotheses, create a plan that will reduce or eliminate the incidence of the problem behavior.

   Take the case of Michael, a five-year-old boy who frequently got into trouble because he bit housemates, house parents, and even strangers -- a common occurrence which prevented him from gaining friends. A plan for him may include the following:

Changing events that trigger biting: Talk to house parents and housemates not to tease Michael by taking away his toy. Tell them about what has been found in problem behavior analysis.

Changing events after biting. Tell the house parents and housemates that if Michael bites them, they should not give the toy back to him. Michael has to know that biting is not an effective way of getting back his toy.

Teaching Michael how to say "No." Teach Michael to say "*Ayaw*" when he does not want his housemates and house parents to get his toy. Practice situations such as letting the teacher take the toy and Michael saying "*Ayaw*" to be able to keep the toy.

6. *Check if the plan worked after a week.* There should be positive behavior change in the child if the plan worked. If the problem behavior continues, the SP should repeat the process of hypothesizing and planning.

What does the SP need to know about effective communication?

Working with and for CSN includes communicating with parents, primary caregivers and a team of professionals and paraprofessionals. Effective communication is a product of understanding the roles that each one plays.

Working with parents

Each family is unique, with its own needs and characteristics. When a child with disability is born, he affects not only his parents but also his brothers and sisters. Hence, it is important to develop services for the whole family and to include families in planning and decision-making for the CSN. An effective SP respects the family's preferences regarding the level of involvement (Gargiulo & Kilgo, 2000).

When talking to parents, be sensitive to their facial expressions and body language. Show interest in their situation especially how they feel about it. Be

positive about the things that they have done and appreciate their efforts. Honesty is also very important but be careful when making comments about what they have done for their child. Be a partner to the parents by helping them find solutions to their problems and by ensuring confidentiality of anything they share with you and other service providers.

Working with professionals

Professionals and paraprofessionals work as a team for CSN. It is very important that each team member knows the roles they each play. As a team, SP and other professionals share relevant and meaningful information that help design them strategies for the child.

Effective SP are observant. They regularly write down significant developments about the child by describing the actual behavior of the child and not using labels. These notes are shared with other team members.

Conclusion

Preparing SP can be a challenge but it is one that is noble and has far-reaching effects on the improvement of lives of children with disabilities.

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CONCERNS AND PROBLEMS IN THE PROVISION OF INTERVENTION TO CHILDREN WITH SPECIAL NEEDS

May T. Cabutihan & Rosalinda B. Perez

Introduction

Establishing, managing, and sustaining an intervention program for children with special needs (CSN) is not easy. Many government and non-government organizations have come and gone, while others continue to thrive and reach out to more CSN even in far-flung barangays.

Programs for CSN will always face challenges. These challenges may come from the clients who will be served, their families, the staff and personnel working in centers, the community, or even from the administration. Despite these challenges, the call to serve remains great. The call to help these children compels one to move forward despite seemingly insurmountable problems.

Problems concerning the clients

The problems with clients stem from their behaviors, their communication, and their health.

A. Behaviors

Each person is inherently good, whether he has special needs or not. This is what support-service givers must believe and hold on to especially when CSN start acting otherwise. Not all clients who will be brought in for intervention, however, will be receptive. Some will be physically aggressive towards authority and their peers. Some will be non-compliant, oppositional, and will get into daily fights and squabbles. Others will steal, tell lies, destroy property, and even hurt themselves. Behavior issues will sometimes create barriers between the helper and the helpee. These should not deter the helpee from moving forward and the helper from reach out to the child who is in need.

A child's behavior is influenced by many factors. There are the biological factors or those inherited from parents which include the physiological make-up of the child, or the neurological factors that make a child with ADHD move impulsively or those that make an autistic child do repetitive movements. There are also the environmental factors which include the home and the community where the child was born and raised. Children coming from broken homes, those who have been physically, emotionally, and sexually abused by family members, and those who have been neglected and abandoned, may tend to become abusive themselves, get into unhealthy relationships, get destructive, pessimistic, and distrustful of others. Then there are the social factors which refer to the child's exposure to his peers who may either be good models or bad. Because of the child's desire to get accepted in a group, he may act in ways that will get him into trouble.

In dealing with negative behaviors of CSN at the centers, the aforementioned factors should be taken into consideration. Where is the child coming from? What has triggered the negative behavior? Find the root case of the problem and start from there. If the child needs professional help from an ABA therapist, counselor, or a psychologist, provide one. Separate the act from the child. Address the problem and not the person. Behavior issues may be addressed best through preventive measures such as the following:

1. Create rapport and establish a positive relationship with the CSN build on trust and respect.
2. Set clear expectations of behaviors. Discuss the rules and consequences of misbehaviors.
3. Praise them for good behaviors. Having seen them do good, acknowledge their behavior through verbal praise, a pat on the back, and a smile.
4. Address small problems before they become big ones. Provide immediate and constant feedback but do so in a confidential manner.
5. Be proactive. Know the triggers and find ways to prevent them.

6. Provide activities that will make them happy and increase their self-esteem. Provide opportunities that will hone their skills, tap hidden talents, and "show off" their gifts to others. Provide tasks and duties that will increase their sense of responsibility and will make them feel that they are making a positive contribution to the center.
7. Teach children how to handle teasing and other conflicts with peers. Teach them different ways to confront issues such as self-talking, ignoring, agreeing with the person, talking to an adult at the center, and talking to the other party using "I" messages.

B. Communication

Not all CSN are capable of expressing themselves and communicating their needs. Some may be totally non-verbal, while others who can speak may exhibit attention-seeking and inappropriate behaviors that mask what they need and what they want to convey to support-service givers. Helpers should be sensitive and compassionate when the CSN resorts to any of these. For non-verbal clients, communication strategies that may be helpful include:

1. Use pictures and drawings,
2. Use gestures and home-made signs,
3. Use sign language, and
4. Read the client's facial expressions and body language.

For verbal clients, communication channels may be improved through the following:

1. Use objective or non-judgmental statements. Instead of saying, "You're a liar!" say, "It has been observed that you have been caught lying several times this past month."
2. Use simple and direct language that is not open to other interpretations. Say what you mean and mean what you say.

3. Tell them **what to do**, not **what not to do**. Instead of "clean up this mess," say, "Pick up the pieces of paper and throw them into the trash can."
4. Actively listen to the client. Give him the opportunity to express himself and respond appropriately to what he has to say, and
5. Avoid nagging and meltdowns. If the client is not ready to talk or listen, give him the space and time he needs.

C. Health issues

CSN who will be brought to the centers may not be at their best health. Some may be malnourished. Others may have an addiction to chemical substances. Some may have ailments such as epilepsy, tuberculosis, hepatitis and sexually-transmitted diseases. Health issues must be addressed properly before providing the needed intervention. Address the child's health problems through regular medical check-up, proper medication, and proper nutrition.

Problems concerning the client's family

A. Lack of family support

CSN need acceptance, attention, care, love and support of their families for the intervention to succeed. Studies show that children who experience neglect, abandonment, maltreatment have low self-esteem, become short-tempered and more dependent on others. This, in turn, affects their relationships, learning, and outlook in life. CSN with supportive backgrounds, on the other hand, and who come from families who can provide adequate financial support, attain higher level of education and are more secure of themselves.

Support comes in various forms. This could be regular visitations or calls to a child who is in a detention center, understanding a child when he gets into trouble, giving reassurance when he is afraid or feels frustrated and discouraged, showing affection to him when lonely, making a child happy, and providing for his material needs. Sadly, not all families are able and willing to provide for

these needs. Reasons include lack of awareness of their child's needs, poverty, and personal issues that hinder them from reaching out to their child.

Lack of awareness of the child's needs. Parents are expected to know what their children need. Having a CSN, however, is a different scenario. Parents must make an effort to know their child's condition or situation, understand how this will affect his total development, and determine his needs. In most cases, they need the help of professionals who can tell them these things. Support-providers must be ready to share and provide access to the needed information and teach families what and why they should be given to the child, and how best to provide these to them. This may be done through counseling, lectures, seminar-workshops, and the like. In so doing, parents learn and understand their child better and become more able partners in providing a good intervention program for the child.

Poverty. Having a CSN in the family poses a great challenge to poor families. Aside from having to struggle for daily subsistence and making sure that the family has adequate shelter and clothing, the poor family has to contend with the additional needs of the child (e.g., medical care, therapy, education). When help comes along, most often than not, they hand over the child completely to the support-provider thinking that they are relieved from the responsibility of attending to him. Justifying that they have other mouths to feed who will be more productive than their CSN, some totally abandon their children to strangers.

Poverty is an issue being faced by the majority. It must be instilled in parents that support-providers are mere "supports" and that they parents remain key players in the intervention program of their child. Doing their share and giving their counterpart whether this be material or not, will give them a sense of dignity and worth. Providing for the clothes and monthly toiletries of the child, visiting the child regularly despite the costly

transportation fares, talking to their child on the phone, attending parent meetings and seminars – these are some of the supports that will motivate and push them to work harder and become better parents to their child. Poverty may mean lack of money to give material things to the child, but it does not mean lack of dignity and sense of duty.

Personal issues. Some families are better in dealing with the challenges of raising a CSN in the family, while others are not. Due to poverty and the pressure of life, others have totally lost hope and have decided to shut themselves away from their child. Others refuse to acknowledge the presence of the CSN. Some become indifferent, while others may be happy to send their child to the center.

When parents and families refuse to offer support to their child and stop all forms of communication, the center will have to take on the responsibility of caring for the child. The CSN will need all the love and care that service-providers can provide at this point. Being neglected and abandoned by one's family has a devastating impact on the socio-emotional development of the child. If not addressed properly, this may lead the child to a life of despair.

Some suggestions on how to deal with a child who has been abandoned by his family are as follows:

- Strengthen his self-confidence and self-esteem by giving him opportunities to do well in his areas of interest,
- Provide counseling sessions. Tell the child that when the time comes, he has to lead a life of his own, become independent and be productive. As early as possible, he must be given the purpose to do well and prepare for that life in the future,
- Help him process internally the reasons why his parents have abandoned him and to make peace with the past,
- Constantly assure the child that support-service givers love and care for him, and

- Establish a mentorship program wherein volunteers (preferably professionals) will act as old sisters or brothers to the clients and regularly do visits and attend to their psychosocial and emotional needs..

B. Lack of trust

Some parents will not immediately trust intervention programs that look ater the specific needs of their child. Some are doubtful as to the motives of the helpers. They ask, "What's in it for them?" Others get concerned and, sometimes, jealous especially if they feel that the child is happy and enjoys going to the center and would rather spend his time there than at home. Sometimes, unknowingly, the program competes with their affection, authority and roles as parents, especially if there are a lot of exciting activities with rewards and incentives at the center.

Intervention programs should promote and strengthen family relationships, and should instill in the minds of the young that their parents are primary caregivers and are partners of the program. Investing in family relationships is longer-lasting compared to helper-helpee relationships which are limited. At times, the child may get too close to a volunteer who may later move out of the center. The loss of a friend will have negative effects on the child especially if he has made an emotional investment and has learned to trust the volunteer. In this event, offer activities that will involve parents who will have to take a more active role in the care of the child.

C. Poor coordination or lack of communication

Families of CSN and the intervention partners need to always have the best interest of the child at heart. Communication problems may arise and one or both parties will be unable to get the message across appropriately. When this happens, those involved in the communication conflict must firs t bear in mind that the one who gets most affected will be the CSN. It is then best to be always open for dialogue, be calm when conflicts arise and use peaceful

resolution strategies, and constantly assure parents that the helpers are on the side of their child.

Problems concerning the center

A. Lack of funding

Supply of food, clothing, materials, medicine, necessary facilities and other needs of special children in centers are all affected by lack of funding. Budget restriction often affects the quality, quantity, and immediately of service and material supplies the CSN need. Lack of funding raises a lot of interconnecting problems, such as manpower and intervention programs. Respondent in the study perceive that the needs of CSN sometimes become secondary matters when funding problems come.

Parents of CSN living in centers should still bear in mind that their participation and involvement in addressing the needs of their child are necessary. They are not exempted from their responsibilities. Parents should look into the situation as a temporary arrangement and no a complete transference of their parental obligations to the personnel and caregivers at the centers. The child's well-being is still the parents' paramount responsibility.

B. Lack of human resources

Professionals and service providers are often scarce in government institutions especially those working at the grassroots level. This situation brings back the problem of lack of funds. Budget allocations are not sufficient to address the salaries and service fees of qualified and dedicated service givers. If there are existing personnel who work with the CSN now, it is because of their unquestionable dedication and love for them in the first place.

Qualified and trained professional who are most wanted to help the CSN (social workers, counselors, therapists, teachers, doctors, psychologists) look elsewhere for other jobs that are financially rewarding. Overseas salaries, salaries in private institutions and multinational call centers are more tempting than those given by government agencies working with CSN.

C. Lack of appropriate intervention program

Appropriate intervention programs for the CSN can only be prepared after a though assessment of their capabilities and incapabilities. Assessment can be carried out by a developmental pediatrician, SPED diagnostician, psychologist, and other trained professionals. The results of the assessment will become the basis for an intervention program that will be prepared for the child. Lack of an appropriate intervention program may also mean that a program is devised but proper implementation has not taken place due to lack of facilities, materials, and professionals to administer it. On the other hand, it may mean that the program prepared for the child is not what is desired to address his concerns. In this case, the qualification and training of the professional who prepared the program come into question.

Problems concerning the community

A. Lack of awareness about CSN

Families and members of the community where the CSN reside play an influential role in the successful normalization of the child through his social integration. It all boils down to saying that children with disabilities and disorders or those with difficult circumstances should be understood and accepted. Community members should have the attitude that values these children's rightful place in society by respecting their dignity as human beings. This can never be achieved if communities and families lack awareness of these children, their needs, and the necessary supports they should receive.

People who are not well-informed, at times, look down upon CSN. Perceptions still exist that children, especially those with physical impairments or those with physical manifestations of the disabilities, are a form of punishment to the families for a wrong they did in the past.

Government, non-government and civic organizations, have started initiatives to spread awareness about these children in the communities. They have advocated for these children's rights, lobbied for the passage of laws that

support CSN and oriented the public on the needs and support these children need. But it seems that these are not yet enough.

People attending and caring for CSN can do their part by educating others in their own small ways and advocating for a better treatment and their acceptance by the community members.

B. Indifference.

It is innate in every Filipino to be helpful and compassionate to others. Knowing their neighbors well, and sharing whatever they have, make them feel happy that they have been made part of their neighbors' lives. They are willing to extend a helping hand, ready to offer advice even when not asked for it. Times have changed though.

Poverty has led to a non-caring attitude of the Filipino. They may be aware of their neighbor's hardships but helping and caring are equated with extending financial assistance or money to the neighbor concerned. The community may be aware that this or that family has a CSN but they just do not care because of the notion that assisting is giving money. Anyway, they think there are government and non-government organizations that will help the CSN. They have their own problems to solve in the first place.

C. Lack of networking and collaboration

Addressing some of the concerns of CSN can be responded to by networking and collaboration between and among professionals and caregivers. This can be very effective catalysts for finding multiple resources and solutions in and beyond the centers to achieve the individual goals for each child. Factors remain, however, that may impede processes to be carried out, such as:

1. Professionals involved may work in circumstances that place them physically and professionally separate from others leading to a limited professional sharing among them,
2. Individualistic orientation, that is, they believe that they are doing their responsibilities and need not collaborate,
3. Hostile relationships among professionals,

4. Time constraints,
5. Lack of collegial trust,
6. Fragmented vision or that they do not share the same vision for the special child, and
7. Lack of administrative support.

Conclusion

The problems in the provision of intervention or CSN may be classified into four types:

- problems with clients (their behavior, communication, and health),
- problems with the CSN's family (lack of family support, lack of trust, poor coordination or lack of communication),
- problems with the center (lack of funding, lack of human resources, lack of appropriate intervention program), and
- problems with the community (lack of awareness about CSN, indifference, lack of networking and collaboration).

GUIDELINES AND STRATEGIES IN TEACHING CHILDREN AND YOUTH WITH SPECIAL NEEDS

Darlene D. Echavia and Susan Janette G. Ealdama

Introduction

Special education teachers need to follow some guidelines to teach children and youth with special needs more effectively. Some experience-based situations may help to get a closer look at what is happening to the kids and why they are acting the way they do. This section presents specific situations culled from actual experience which may provide models and lessons on how special education teachers may teach children and youth with special needs. Obviously, it is impossible to discuss all of the special conditions that may probably be seen in children inside the classroom. But it is possible to give some ideas of how we may intervene when we see some out-of-the-ordinary behaviors in our classrooms. Each situation is discussed along the sequence of:

- **What's happening?**
- **Why?**
- **What can we do?**
- **Let us remember!**

Situation 1: Ken

What's Happening?

While singing routine "good morning" songs, you notice a kid running about non-stop inside the room as if someone has been chasing him. You instantly remember that Ken has difficulty finishing his seatwork and cannot seem to wait for his turn when lining up to wash his hands before recess.

Why?

Three major problems are present in Ken's case. One is his non-stop running; two, his difficulty in finishing his seatwork; and three, he cannot seem to wait for his turn.

Ken's non-stop running is due to hyperactivity. As such, he needs to use up his excess energy before he can settle himself to calmer, sit-down activities. Hyperactive children get to be more excited when there are too many loud and fast sounds around them.

His difficulty in finishing seatwork is that he gets easily distracted by movements, sounds, and colors around him. He may have been feeling uncomfortable but is not able to express what he is feeling. Sometimes, the seatwork itself may have been too difficult to match his level.

His not being able to wait for his turn is again due to hyperactivity and impulsivity. His body prompts him to keep on running. To stand still is not natural for him to do.

What Can We Do?

To prevent the non-stop running of children like Ken, the following may be suggested:

- Give time before the start of class for the child to play in the playground (mostly on the swing) as part of his routine.
- Start with fast and active songs and end with slow and calm songs.
- You may ask the child to stand beside you, or the teacher, to serve as the song leader. This will make it easier for the teacher to keep the child busy and productive.
- If the child is still excited, help him use his energy in ways that are more useful, like calling him to paste markers on the wall, to open and close doors, to take off markers that are not needed, to return objects to their proper places after an activity is done, and similar classroom tasks.
- Praise and thank the child for his efforts.

To attend to the problem of the child having difficulty in his seatwork,

- See to it that only necessary objects are found around his working area
- Avoid using too many colorful pieces of paper around his working area.
- Maintain a calm and quiet classroom to help the child focus on the activity.
- Check if his table have markings, stains, or glare that distract him from focusing on his work.
- Make sure that the child is feeling well.
- Check if the task to be done is indeed within the child's level.
- The seatwork may be cut into smaller parts to help the child finish it without being discouraged of its length.
- The child may be given a short break (stand up, walk around the room once, change position) in between the task to be done. As the child matures, the breaks may be lessened and the tasks lengthened little by little.
- Praise and thank the child for his efforts.

As to the problem of the child not seeming to wait for his turn,

- Place the child in the second or third position in line so that he/she may not have to wait for a long time. As he matures, he may be placed at farther positions to train him to wait.
- Stay beside the child as he tries to wait for his turn.
- Give him a concrete idea of how long he will have to wait. Tell him gently to do so, for example, after five counts.
- Count softly beside him and with him from one to five. Gently tap hi shoulders as you count to catch his attention. Be true to your promise of letting him go after finishing five counts.
- Praise and thank him for waiting after finishing the count and before letting him go.

Let Us Remember!

- Hyperactivity and impulsivity are not within the child's control. Scolding by asking him "Sit down!" may not work. Help him have control over his behavior so that he may sit down when he has to.
- A calm and modulated voice definitely helps the child to calm down and focus on what the teacher is saying.
- A clear and clean working environment will already help the child to focus.
- Be true to your promises especially when you want to let him know of the rewards he may have after finishing the tasks.
- Praise and thank the child for his participation.

Situation 2: Allan

What's Happening?

During free play, Jon goes near Allan who was playing alone. Allan suddenly hits Jon with his toy car. When you come to stop them, Allan starts screaming and crying. He rolls on the floor while banging his head against it.

Why?

Three problems are presented in Allan's situation. He plays alone; hurts self and others, and cries and throws tantrums.

Playing alone means that the teacher has not sensed the need for a hyperactive child to use up his excess energy. That is why Allan screamed, cried, rolled and banged his head on the floor because it was his way of releasing his extra energy.

Hurting oneself and others may have been the result of children who are not yet able to talk and can only communicate through physical means. When the child feels that there is a threat to his safe place, the natural tendency is to protect oneself expressing it through aggressive means. Head banging may

also be the child's way of getting attention especially if, in the past, he was able to get what he wanted after he displayed a similar aggressive behavior.

The child crying and throwing tantrums could be due to his difficulty in speaking. Crying and throwing tantrums become ways for non-speaking children to express displeasure. This may also be a sign of confusion and alarm on the part of the child. Often, when the child immediately stops crying after being given a toy or some goodies, the behavior may be his way of getting what he wants from people around him.

What Can We Do?

In dealing with a child who plays alone, the following may be useful:

- Let him have his personal space and time to play alone for some time. Let this place be within the classroom and not far from the rest of his classmates.
- Look for one person whom the child can bear to be with or whom he considers as his "friend" to be his playmate or companion in their play. He may be a classmate, a sibling, or his own parent.
- Ask the "friend" to play with the child during playtime in the classroom. Ask one other classmate to play at a tolerable distance from the child and his friend.
- Each day, try to bring the classmate closer to the child and his "friend." When the child shows tolerance over the presence of the classmate, the "friend" may move away little by little until the child can be left with his classmate.
- Eventually, other classmates may come close to the play circle until the child is able to tolerate more children around him and share spaces with others.
- Always praise the child for his friendly behaviors.

When the child tends to hurt himself and others, the following strategies may work:

- First, make sure that the toys and objects around the child are of soft materials to lessen unforeseen situations.
- Ensure that each child in the classroom knows and understands the importance of asking permission and borrowing toys before they get them.
- The phrase "May I borrow" may be practiced in class with gestures (point to object an then palm-up) to serve even non-speaking children.
- Turn-taking in playing with toys may be a good part of the class routine so that each one has a sure chance of playing with the toys.
- Prepare rubber mats and pads to cushion the child's head if he shows head-banging behaviors.
- It is important not to present the toy or the desired object as a bribe to make him stop during the head-banging bouts. Instead, give him the desired toy or object as a reward when he stops.
- Do not comment as you deal with the child currently banging his head on the floor. But praise him lavishly when he stops his behavior.

The child's crying and throwing tantrums may be handled as follows:

- When critical situations happen, try to maintain a calm voice as you try to prevent the children from further hurting each other. A loud hysterical voice may only heighten the emotions of the child which may lead to further tantrums.
- Take the toy away and move the children apart from each other.
- It is useless to explain to the child when he is still screaming and shouting. Simply make sure that there are no sharp and hard objects around which may be picked up by the screaming child to hurt others.
- As much as possible, ignore the disruptive crying and screaming behavior.

- Wait for the child to calm down before paying attention to him and even praise him that he stopped crying and screaming.
- Simple explanations may be done when the child gets to calm state.
- The preferred toy may also be given back to him only when he stops crying and screaming.

Let Us Remember!

- Because of the child's limitations in speaking, there will always be critical situations in the classroom. It would be better to think of preventive actions.
- Alternative means of communication, a stable routine in class, and a safe classroom environment would be o great help.
- Be constant in targeting the behaviors that you want to eliminate in the child.
- Involve all the people who are helping the child especially his family.

Situation 3: Vannie

What's Happening?

Vannie is a five-year old girl who is very eager to tell stories. However, she can only use one word when she wants to ask for something or tell something about herself. You notice that Vannie drools and that her tongue usually sticks out. When action songs are sung, she does not follow the actions even if she likes the songs. When asked to imitate simple words, she looks and smiles but is not able to do the task.

Why?

In Vannie's case, the major problems are: she uses one word when she speaks, drools (*naglalaway*), keeps mouth open, tongue always sticks out, does not imitate actions in action songs, and does not imitate words.

People are usually concerned that the child cannot speak yet. But it would be good to know that learning how to say words is a step-by-step process. The child needs to master some skills first before she can finally speak better.

Speech is a very difficult task for the developing child. She will not speak properly if the speech muscles are weak. Drooling is a sign of weakness of the lips. The lips are very important parts of speech. Speech muscles must then be exercised for the lips to get ready for speech.

Tongues sticking out may be a sign of tongue muscle weakness. Like the lips, there is a need to exercise the tongue, too, to help it get ready to work for speech.

What Can We Do?

There is a step-by-step process to overcome the condition that ails Vannie and other CSN.

- Minimize drooling. Enhance closure of the mouth by doing these exercises:

    a. lightly tap around the lip area of the child following a clockwise motion to enhance contraction of the lip muscles
    b. quickly and lightly stretch down (*kalabitin*) the middle part of the child's lower lip. The child will reflexively close her mouth instantly
    c. remind the child to swallow her saliva
    d. to help the child swallow her saliva, slightly bend her head down and gently massage the neck area
    e. practice sipping through straw to further strengthen her muscles
    f. notice an praise the moments when the child closed her mouth and did not drool

- Enhance the strength of the tongue muscles so that it will not stick out.

    a. swipe a small amount o peanut butter (or any cream filing or jam which the child prefers) on the child's palate and ask her to clean it up with her tongue

b. when brushing her teeth, brush also the tongue using gentle strokes of the toothbrush
c. ask the child to push her tongue against her cheek and push it back in with your two fingers

- Encourage the child to imitate big to small actions.
  a. sing and perform action songs involving movements of the whole body, especially the arms and legs (*paa-tuhod, ikot-ikot,* twinkle-twinkle, fly fly butterfly…)
  b. guide the child's body as she tries to perform the actions o the songs
  c. allow for flexibility relative to the speed and the rhythm of the songs
  d. introduce action songs involving movements of the fingers (eensy-weensy spider…)
  e. place your hand over the child's hands as you guide her in doing the actions of the songs
  f. prayers and poems may also be coupled with actions to further give the child the opportunity to practice imitating movements
  g. praise the child for her efforts to imitate

- Encourage the child to imitate simple and familiar words.
  a. repeat the target word to the child within meaningful contexts (example: repeat the word "dog" while the child sees the dog running or barking in front of her)
  b. go down to the child's eye level and call her attention to you as you point to your mouth
  c. say the word slowly and clearly making sure that each sound is heard

d. point to the child's lips to indicate that it is her turn to imitate
e. wait for the child's response
f. praise the child's effort ("Good try!") and wait for another moment to repeat the process
g. do not aim for perfect imitation even after two or three trials; rather maintain an accepting atmosphere to give the child the motivation she needs so that she'll keep on trying

- Encourage the child to speak.
    a. engage in various activities of interest to the child
    b. during the activity, gently speak about what is happening beside the child, at her eye level
    c. use simple and familiar terms; use the language the child is most familiar with
    d. highlight one or two words in an activity and ask the child to imitate it after you give the child a good model
    e. as before, maintain an accepting atmosphere and praise the child for her efforts

Let Us Remember!

- We need to wait for the child's readiness for the tasks we want her to learn. We cannot go beyond the step-by-step process.
- While waiting, be patient and active in helping the child get ready for the skill.
- Be generous in the praises t5o give the child the confidence she needs.

Situation 4: Angie

What's Happening?

Angie is 10 and likes very much to do art activities but her hold or grasp of the crayons and the art materials is such that these easily fall from her hands.

She has a hard time picking them up from the floor. When coloring, her strokes go here and there leaving patches of uneven shades. She also finds it hard to fold paper and cut with scissors.

Why?

Angie's problems includes six difficulties: the difficulty in holding objects, in picking up objects, in managing writing/coloring tools, in folding paper, and in cutting with the use of scissors.

Angie seems to have problems with her hands. It may be that her muscles are not strong enough to help her do the things that she wants to do. Also, her muscles may be strong but are not working in harmony with each other. To do the actions mentioned above, one must be able to master very fine and complicated movements of the fingers which is not always easy for CSN.

What Can We Do?

Support-givers can develop Angie's muscle strength and coordination by the following routines:

- Massage. Using lotion or baby oil, gently massage the child's arms starting from the shoulder area to the tips of her fingers. Clasp her arms as you would hold a baseball bat and slide them down to her fingers with gentle twisting movements as if you were wringing laundry. This will help stimulate her hands to get her ready to exercise some more.
- Squeeze. Give her colorful squeeze balls to practice with. Ask her to squeeze the ball and hold the pressure for five seconds before relaxing. This may be repeated several times giving the child enough time for rest in between the repetitions. Hold her hand to guide her t6hrough the activity if she needs it. At home, she can be asked to squeeze clothes in the laundry or squeeze the dough in baking. You can also put peanut butter or her favorite spread in a clean and durable plastic bag. Seal the opening and make a small hole in one of the pointed corners of the plastic

bag. Let the child squeeze the jam or butter out on to the bread for her snacks.

- Clip it. Manipulating the clothespin is a good exercise for the fingers. Ask the child to hang paper art works on a string using clothespins. She may need some help from you at the start. Never mind if it takes her a long time before she can hang one piece of art work.
- Pick up. Ready some beads and marbles mixed in one tray and two separate containers (cans with small openings). Ask her to separate the beads from the marbles by putting all the marbles in one can and the beads in the other. Guide her fingers in picking up the beads and marbles and placing them in the cans. Use bigger beads and marbles or cans and bottles with wider openings if she is having a hard time. She may also be in charge of placing pencils and ball pens in cans designated for them.
- Shoot the straws. Line up empty bottles and used straws. Ask the child to shoot the straw into the opening of the bottle. Guide the child in the first few bottles and give the child the chance to do it on her own.
- Color big time. Give her big figures with less detail to color on. This will give her the practice she needs without having to worry about going outside the line. Also, make the lines of the figures thick enough for her to be more conscious of the boundaries. Remind her to try to color within the lines.
- Consider changing the writing tool. Instead of giving her the ordinary pencil or crayon to use, choose big and thick crayons and pencil which will be easier for her to hold. It is also possible to wrap the regular-size pencil with tape or rubber band to make it thicker.
- Folding. Practice the child's folding skills. Let her fold semi-hard paper like the cartolina which already have fold marks on them. This will give her a guide in performing the task. Guide her hands as she folds the paper and point to the fold marks of the paper as you help the child. You can also use shoe boxes for practice. Unfold the box and spread it before the

child. Guide her to fold the box again following the marks. Gather used envelopes and unfold them. Guide the child in folding the envelopes following the fold marks. Later on, you can guide the child in folding paper with lines as markers. Folding can be made more fun through art projects. Make personalized envelopes, fancy boxes, paper fans and other simple paper folding designs.

- Cutting with scissors. Write straight lines on a piece of paper and let the child cut the paper following the line. When the child masters the art of cutting straight lines, draw a simple figure with straight lines (house, buildings, boxes, simple table, simple chair…) so that she may cut it. Later on, cutting curve lines may be done. Cutting circles and more complex shapes may be given later. You can work on a scenery project where figures must be cut from colored paper (example, a house beside a tree, with mountains at the back, and the sea at the far end).

Let Us Remember!

- Learning skills is a step-by-step process. So we cannot expect the child to be good in folding and cutting if she does not have the strength and coordination of the muscles needed to finish these tasks. Let us give the child the time and space she needs to learn.
- Be creative in giving the child activities that will help her practice the skills she needs to develop. Use her interests and do not force her into activities which she does not like.
- Learning can be done at the same time as doing house chores. Use these natural situations to give the child the practice she needs. Take advantage of activities such as cooking, cleaning, bathing, dressing, etc.
- Hand-over-hand assistance may be needed for the first few trials of the child. Place your hand on the child's hands so that you may hold and guide her as she does the activity. Let us not do the activity for the child even if it may mean taking some more time before the chores are done.

- In showing the child what to do and how to do a particular skill, be slow and clear. Show the child one step at a time. Wait for the child to finish imitating before showing the next steps. Talk slowly, using simple words. Tell the child what you are doing while you are doing it. Call the child's attention to make sure that she is following you.
- Do not mind it if the child finishes after a long time. Never mind if the end product is not at all perfect. As long as the child tries her best to do what you showed her to do, let us accept her efforts and praise her for it.

Situation 5: Janet

What's Happening?

Janet is nine years old and she easily forgets things taught to her. She can say her name and her age when asked but not her address or telephone number. She has limited concepts which makes it hard for her to talk to other people. She talks using one or two words like, "*Kain Janet*" or "*Alis mama!*" Her speech is not always clear.

Why?

Janet's problems are: she easily forgets things and lessons, cannot give personal information, has limited concepts, suffers from delayed speech, and has unclear speech. This may be attributed to an overall immature development due to the presence of intellectual disability.

What Can We Do?

To help her remember, the strategies may be:

- Sing a song. It is easier to memorize words when sung because the words ride on the melody and rhythm of the song. To help Janet remember better, put the melody or rhythm on the words to be memorized and practice it many times. Let the child hear it and then say it with you. Important information such as personal information may be

reviewed through singing it everyday until this becomes automatic to the child. Some pop songs may be used to help her learn words too.

- Say it and move it. Some children learn better when parts of their body are moving. Action songs are very effective in helping the children remember concepts because the words ride on to the movement. Sometimes, saying the word and doing movements with the hand are enough. For example, in teaching the concept "big," you can open wide your arms. For the word "small," you can do a gesture with your fingers.
- Say it, see it. It would be great to have colorful pictures of the words that the child is learning. To help her remember, write her name and address beside her picture and that of their house. You can also ask her to draw herself and their house and write the information beside it. Say her name and address while writing it.
- Say it, feel it. Get some sand and spread them over a flat tray. Ask the child to write her name on the sand. Guide her hands as they slide through the rains and say her name aloud. Ask her to say the name while writing and rewriting it.

To help the child understand and speak, corresponding strategies are:

- Talk to the child. Talk to her not only when she asks or wants something but as often as possible. Talk to her about what she sees, what is happening around her, what she hears, what she feels. Talk to her and point to the event or the object which you are talking about. She does not have to answer. She only has to look and listen.
- Modeling. Focus on one word. Go down to the eye level of the child. Ask to look at you. Say the word and point to her and wait for her to imitate. Say the word again one syllable at a time and ask her to repeat one syllable at a time also. Accept her effort even if she did not get it correctly and praise her for it.

- Level up. When the child uses incomplete words (e.g., "*Alis mama!*"), repeat what she says using more correct patterns ("*Aalis si mama*"). Try to make her the more correct patterns. Praise her for her efforts but do not force her if she cannot say all of the words. Repeat the same pattern to help her remember it better (e.g., *"Aalis si papa," "Aalis si Janet," "Aalis si kuya"*).

To help the child speak more clearly,

- Slow down. Remind the child to slow down when she starts speaking with unclear words. In this case she is *bulol*. Ask her to stop first, take a deep breath, and then say the word again.
- Fewer words. Sometimes, the child has a hard time speaking because she wants too many words. Pick out the important word in what she wants to say and repeat it to her clearly and slowly. Ask her to repeat the words in her turn.
- Rhythm in speech. It would help if the teacher stresses the rising and falling tones of words (accent) when the child is asked to repeat what the teacher says. This can be done with gestures of hands going up for stressed syllables and hands going down for unstressed syllables. Rhythmic patterns may also be added to sentences.

Let Us Remember!

- Children learn better in a happy and accepting environment. Keep the atmosphere joyful and give a lot of praises.
- Be creative. Use home chores and find the child's interest. The child can remember faster if she is interested.
- Perfection and speed is good but it can come later. Give the child the feeling that she can speak and people can understand her. Build in her confidence to speak first before building on perfection.

- Be clear, slow, and simple in giving examples. Since the child is slow to understand, the need is to use slower speech too and to be clear with it. Talk to the child with good rising and falling tones.
- Do not shout. If the child does not do what is commanded of her, it is not because she did not hear but because she did not understand it yet. Repeat the command with a clear and slow pace.
- Patience is already 70 percent learning. The child feels it when the teacher or service giver is impatient. Teachers and caregivers must also stop, take a deep breath, and even get out o the situation first when they feel irritated due to the endless repetitions.

Situation 5: Nina

What's Happening?

Nina is a 5-year old girl. Although she has no hearing impairment, she does not respond to people when she is called and would just continue playing alone. When the toy she is playing with falls to a far corner, she would leave it there and find another toy. She seems to ignore simple commands. She was not yet observed to name familiar objects or to point to these objects when asked to do so.

Why?

Nina has not yet mastered some "redying" skills that will enable her to perform the above-mentioned demands. These "redying skills" include:

- Cannot seem to follow simple commands
- Does not point to familiar objects
- Does not look when called
- Does not look for lost or hidden objects

Learning the importance and the process of communication may not be an automatic process for some kids with special needs. They will have to learn its sub steps through the help of more knowledgeable individuals around them. As they are able to perform each step more effectively, they will also learn how to listen, understand, and make their needs known to others as well.

- Step 1: Look at the person who is calling attention
  - To catch the right information, one should pay close attention to whoever is talking to him or her. Looking at the person who is talking is one way of enhancing attention to the communication partner.
- Step 2: Follow moving objects with eyes
  - The attention one gives to the communication partner should be sustained and should follow the movements of the speaker as well. There will be important details like movements of the eyes, lips, and head that will give enriching information as well. Following moving objects with the eyes is an exercise to focus sustained attention to an object which will eventually be the communication partner.
- Step 3: Search for hidden objects
  - If the child does not search for toys (especially those which he or she likes very much), hidden from her sight, it may be a sign that the child does not yet understand that these objects exists even when they are not seen. This knowledge is a foundation for understanding the importance of words and that they have meaning. We can actually use words to talk about things that are not within our sight because words represent these things.
- Step 4: take turns when playing
  - When talking to other people, we exercise a give and take relationship. When one gives information, the other listens in

order to respond correctly when his turn to talk comes. Being able to wait patiently for one's turn in games which require turn-taking skills is a foundation of effective communication.

- Step 5: pointing to objects when named
  - Pointing to familiar objects when named is a simple way of showing understanding of names of things for a child. They may not be able to say the name at the early stages but they are already associate the name with the object.
- Step 6: following simple commands
  - A higher level of understanding the meaning of words is needed in following simple commands. By this time, we may expect that the child has memorized receptively not only names of objects but also action words, prepositions, and describing words.

What can we do?

- Step 1: Look at person when called
  a. Every time you have to give the child something she wants (a toy, food, etc.), call her name first and wait until she looks at you before giving her what she wants.
  b. In calling her name, make sure to leave at least a 3-second pause in between the calls to give her time to process the sound she hears.
  c. Go down to the child's eye level to make it easier for the child to see you since she does not have to raise her head in order to look at you.
  d. Place the object that you want to give her close to your eyes (beside your head at the level of your eyes or just below your eyes to help the child in her effort to look.
  e. Immediately give the object to her once she looks at you and praise her for looking at you, and reward the behavior further with a smile.
  f. Be consistent in this training until she responds automatically by looking at the person calling her.

- Step 2: Follow moving objects with eyes
  a. When the child is already able to tolerate a longer time to look at the person calling her, we may challenge her a little more by moving the object slowly to one direction for around 5 seconds (depending on the child's tolerance level) before handing it over to her.
  b. Playing with colorful, moving toys like toy trains and cars may also help to motivate the child to follow a moving object with her gaze. As the toys move, point to it with your hand in order to guide the child's eyes.
  c. Playing with bubbles is also an effective way to encourage children to follow movements with their eyes. As the bubbles float around the child, point to one bubble to guide the child's eyes.
  d. Always talk about what is happening in front of her. Example: "Wow, the train is moving…there it is…there it is…choooo chooo chooo…"
  e. Always praise the child's effort.

- Step 3: Search for hidden objects
  a. Take one of the child's favorite toy and dangle it before her.
  b. Call her name to it to make sure that she is looking at it.
  c. Move it slowly to one direction while talking about what is happening ("The toy is moving slowly…slowly…there it is…").
  d. Hide the toy in the presence of the child (under a pillow or a towel) and call her attention to it ("Oh no, the toy is gone! Where is the toy? No more! The toy is gone...).
  e. Call the child's attention to the place where she saw the toy being hidden (point to it: "I think it's there…") and slowly uncover the toy ("There it is! There is the toy!).

f. We may repeat the same routine several times and little by little give the child a chance to find the toy herself until she spontaneously looks for toys hidden just in front of her.
g. Asking the child "where is the…?" is a good way of reminding her that there is something missing.
h. Since she may not be always ready to look for it, you may show the child where the toys were hidden and let her be the one to uncover it.
i. It is good to consistently hide toys in one place only to help the child remember. This way, even if she did not see us hiding the toys, she would still be able to locate it when asked.
j. As the child gets better in this game, we can use other hiding places as well.
k. Make the learning process fun and praise the child for her efforts.

- Step 4: take turns when playing
  a. Playing "peek-a-boo" or "hide and seek" is a wonderful way to encourage the child to take part in a game.
  b. Make sure that the child waits for a few seconds before the surprise comes.
  c. The length of time that the child spends in waiting for the surprise may be lengthened little by little as she is able to tolerate longer waiting.
  d. Other "take-turns" game may be catching and throwing a ball or a stuff toy, passing the ball from one child to the next while singing a song, sharing manipulative toys, etc.
  e. Always praise the child for playing well and for waiting for her turn during the game.

- Step 5: pointing to objects when named
  a. Ask the child "where is the (name of object or person you want her to point)?" and be the one to answer for her: "There" (coupled with pointing gesture).
  b. Model to the child the pointing behavior and make sure that the child is looking at the direction to which you are pointing.
  c. Assist the child physically in doing the pointing gesture. Put your hands over her hands, extend her pointer finger while "closing" the other fingers.
  d. Give the child a lot of opportunities to see new and attractive things to encourage her attention on things around her.
  e. Repeat the same question-and-answer play ("where is the ___? There – point gesture) especially when the child's attention is drawn towards a particular object.
  f. Always praise the child for her efforts.

- Step 6: following simple commands

  Commands like "give me/to __, point the __, close, open, and other simple actions may be easy for the child to follow provided that:

  a. The child is physically ready to perform the command you give.
  b. Someone shows the child how to do the action demanded and repeat it several times.
  c. The commands are coupled with appropriate gestures (palm-up for "give me", pointing hands for "point to___", etc).
  d. The child is rewarded for her efforts.

Situation 6: Weng

What's Happening?

While sitting and waiting for her lunch, Weng continuously rubs her hand and flaps them at her side. She was also excitedly moving her hands back and

forth her face against the light just above her. These are her usual behaviors whenever she has nothing much to do.

Why?

Weng's behavior is not helping her to wait calmly. She may be doing these things because of her hyperactivity and because she needs to feel her hands moving. Even the light filtered by her hands also excites her eyes. These behaviors are going to block her from learning if not stopped or at least reduced to a minimum.

What Can We Do?

- Give the child something to hold to keep her hands busy. Instead of rubbing and flapping her hands, she may play with a piece of clay or flip the pages of a book for example.
- Puzzles, colorful magazines or pictures that she likes may be placed on the table to keep the child from focusing on the light above her.
- Press her hands gently but firmly to supply her the feeling she is looking for. Hold the pressure on her hands for 5 seconds then release then press again. This procedure may be repeated several times while you talk to her in a calm and low voice saying "press the hand" or counting one to five gently.
- Clasp the child's hand with your one hand and hold the child's forearm with your other hand. Move her wrist gently, slowly and firmly going up and down. (insert picture) When you have reached the highest and the lowest points, hold for 5 seconds. Repeat several times while saying "up" and "down" gently or counting one to five.

Let us remember

- It is important to be consistent in giving the child something to do to replace the flapping and rubbing behaviors.

- Do not wait for the child to do the rubbing and flapping before giving her the toy. It is better to look ahead and prepare things in advance instead of correcting the behavior when you see it.
- Praise the child when she is not flapping or rubbing her hands by saying "good hands". When we are always doing this, the child will eventually understand what "good hands" mean.
- It is important to use a calm and relaxed voice when talking to the child. An excited voice will also excite the child and it would be much harder to help the child when she is excited.
- When the child is not busy with an activity, they can do distractive means to busy themselves. So, let us keep them busy and productive to encourage "good hands" behavior.

There is no one recipe that would cater to all children with special needs. Each child is unique and would therefore need an individualized plan to enable him or her to reach his maximum potential. With a lot of flexibility and creativity, we can tap into the interests of the child to come up with motivating activities geared towards further developing their skills. After all the readings and trainings, we must not forget that it takes more than just technical knowledge to build these children's future. Behind a tireless creative mind, there must also be a heart full of persevering faith.

To further give us ideas as to what lessons we may teach children with special needs and what activities may be done to facilitate the learning of skills, a matrix of educational goals, curricular priorities, and sample lessons can be found at the end of this book (please see Appendix A). Please note that while the priorities are developmentally arranged, the matrix does not present the whole range of lessons that a child would special needs would need to learn. Rather, the matrix presents some examples of curricular priorities with their corresponding lesson plans. The adaptation and expansion of the curriculum and

the lesson plans found in the matrix is highly recommended. For this latter task, the knowledge and creativity of the facilitator is needed to match the needs of the children in focus.

ADVOCACY FOR CHILDREN WITH SPECIAL NEEDS

Edilberto I. Dizon

Parents, teachers, service-providers and everyone else assume the responsibility of protecting and supporting children with special needs (CSN) through specific formal and non-formal advocacy programs and services. Such advocacy efforts need not be through huge rallies, protest marches and conference participation! Advocacy through our day-to-day interaction with others and through media tie-ups can best exemplify the potent power of joining hands together. Together we can meaningfully relate in the best interest of the CSN.

Adhering to worthy causes anchored on strong pro-humanity ideologies/perspectives and consistent with one's convictions is most significant in reaching out to different publics. Such is a testimony of our unshakable stand that every CSN deserves respect and recognition of his/her potential for productive living in the mainstream of his/her community.

Advocacy for CSN is expressing your thoughts and feelings, asserting your voice through different avenues. This may be a letter to a newspaper editor, a call to the public-service host of a radio station, or a letter to your legislator. This may be through a fun-run in support of CSN, or a video/film viewing about the courage, the meritorious deed of a CSN. This may also be through an exhibit of the creative works of CSN, or membership in a support organization or a volunteer group enabling you to share experiences, observations and ideals, and actualize services for CSN. Advocacy can be through genuine and positive response to calls for some services and financial/material assistance published in papers or announced over TV programs; or, through teaching young people to visit websites of disability/support programs/organizations.

Through different advocacy modes/projects, what can we convey about CSN? Some priorities are the following:

1. Information about different disabilities and their effects on the CSN's behaviors, learning/cognitive achievements, and physical/motoral and self-care conditions/levels.
2. Children with special needs— just like all others— need good and adequate nutrition, attention, care and love; good and appropriate education; and, good role models and support services. They, too, have feelings and emotions: getting hurt/offended, feeling good, accepted or rejected.
3. Communicate with CSN. They may not be able to communicate verbally well but they can use other communication models: pointing, miming, gestural or facial cueing, signing, drawing and using pictures. By listening to and communicating with them, they are better understood and can relate better as they get less physical - hurting, pushing or hitting.
4. Take off your fear of CSN. Trust the child. It may just take a warm, accepting, giving and loving relationship that he/she needs to bring out his/her potential for relating positively.
5. Do not instill among children including in the CSN himself/herself, the attitude/culture of pity. This impedes his direction toward self-confidence and self-actualization.
6. Do not label the CSN. Labels have different meanings to different people. People get to know him/her by such negative labels. These rob the child of the chance to be understood and taken for what he/she is: a child with a unique personality and potential for becoming. Labels stay on throughout life— even if the child has risen from his/her deficits and surpassed his/her disability benchmarks.
7. Teach the CSN to be independent in performing different tasks especially in the areas of self-care and chores performance. Focus on what the child can do more than what he cannot or can never learn to do. Let his/her strengths compensate for/offset his/her limitations.

With the best of intentions and a firm commitment to pursue no end what is best for the CSN even in our little ways, we can all be ONE in making our world a safe, happy, comforting and inspiring place for every child with special needs!