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**The Rainbow of Diversity**

Children with special educational needs, families, teachers, community.

O1/12/2017 – 30/11/2019

***Documents of a comparison between different experiences.***

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# 1 . DESCRIPTION OF DISABILITY

## The definition of disability - By Italy

It is not easy to determine how many disabled people are in Italy. The problem is related to several factors. First of all, that of "disability" is a non-universal concept. Very often its definition is linked to the researcher or the type of research being carried out. In many cases, moreover, the terms "invalid", "handicapped", "disabled" or "disabled" are used inaccurately, or are confused with one another.

In this text it was decided to follow the indications adopted by ISTAT which, in turn, makes explicit reference to the definitions of "disability", "disability" and "handicap" illustrated by the World Health Organization.

The term "disability", for example, refers to the ability of the person to independently perform (even with aids) the fundamental activities of daily life and leads back to the law 104 of 1992. The term "invalidity" refers to the right to receive an economic benefit as a result of biological damage regardless of the overall assessment of self-sufficiency, and refers to the law 118 of 1971.

But, to clarify the terms that will be adopted, it is useful to examine the two documents drawn up by the WHO.

WHO specifications

ISTAT adopts the definition of disability proposed by the World Health Organization in the "International Classification of Impairments, Disabilities and Handicaps" (1980) (18). The focal point of this classification is the sequence of definitions that leads from impairment to disability: the impairment is the biological damage that a person reports following a disease (congenital or not) or an accident; disability is the inability to carry out the normal activities of daily life following the impairment; the handicap is the social disadvantage that derives from having a disability. Thus, for example, a person in a wheelchair is certainly disabled, but could potentially not be handicapped if all architectural barriers were removed, so that access to any sector of social life would not be precluded. It is evident that, in this sense, we can count the number of disabled but not disabled people; the handicap condition is purely subjective and depends on the life expectancy and the needs of the disabled person.

The first WHO document (ICIDH)

In 1980 the World Health Organization published a first document entitled International Classification of Impairments, Disabilities and Handicaps (ICIDH). The text made the important distinction between "impairment" (impairment), understood as "loss or abnormality of a psychological, physiological or anatomical structure or function", and the other two terms. These were respectively defined as: "disability" (disability) as "any limitation or loss (consequent to impairment) of the ability to perform an activity in the way or in the range considered normal for a human being" and "handicap" such as the "condition of disadvantage consequent to an impairment or a disability that in a certain subject limits or prevents the fulfillment of the normal role for this subject in relation to age, sex and socio-cultural factors ". The list of the main groupings in the definition of each of the three terms, given below, can better help to understand the distinction.

**Impairments**:

impairments of intellectual capacity;

other psychological impairments;

speech and language impairments;

ear impairments;

eye impairments;

visceral impairments;

skeletal impairments;

disfiguring impairments;

generalized, sensory and other impairments.

**Disability:**

disability in behavior;

communication disabilities;

disability in the care of one's person;

locomotor disabilities;

disabilities due to physical condition;

disability in dexterity;

circumstantial disabilities;

disabilities in particular activities;

other business restrictions.

**Handicap:**

orientation handicap;

handicap in physical independence;

mobility handicap;

occupational handicaps;

handicap in social integration;

handicap in economic self-sufficiency;

other handicaps.

To give an example, based on the definitions that have been specified above, a blind person is a person who suffers from an eye impairment that causes him disabilities in communication and locomotion and involves handicap, for example, in mobility and employment. This example is useful to understand how a single type of disability can give rise to more types of disabilities and imply different disabilities.

Similarly, a certain type of disability can be linked to different disabilities which in turn can result from more than one type of disability. While for an individual the impairment has a permanent character, the disability depends on the activity that he must exercise and the handicap expresses the disadvantage he has towards other individuals (the so-called normal). A paraplegic will certainly have a handicap when it comes to playing soccer, but he may not have anyone to use a personal computer.

The new WHO document (ICF)

The significant aspect of the first document published by the World Health Organization was to associate the status of an individual not only to functions and structures of the human body, but also to activities at an individual level or participation in social life.

The second document is entitled International Classification of Functioning, Disability and Health (ICF) (19). The title is indicative of a substantial change as it emphasizes a unification in the forms of describing a person's status. We are no longer referring to a structural or functional disorder without first relating it to a state of "health".

As you can see from the tables below (the official Italian translation of the WHO document is not yet available) the new document replaces the old “impairment”, “disability” and “handicap”, which indicate a lack to reach the full "functioning", with a different terminology.

**Body functions:**

mental functions;

sensory functions and pain;

voice and speech functions;

functions of the cardiovascular, hematological, immunological and respiratory systems;

functions of the digestive, metabolic and endocrine system;

genitourinary and reproductive functions;

neuromusculoskeletal and movement-related functions;

cutaneous functions and associated structures.

**Body structures:**

structures of the nervous system;

eye, ear and related structures;

structures related to voice and speech;

structures of the cardiovascular, immunological and respiratory systems;

structures connected to the digestive, metabolic and endocrine system;

structures connected to the genitourinary and reproductive system;

movement-related structures;

skin and related structures.

**Activity and participation:**

learning and application of knowledge;

general tasks and requests;

communication;

mobility;

personal care;

domestic life;

interactions and interpersonal relationships;

main areas of life;

community, social and civic life.

**Environmental factors**:

products and technology;

natural environment and changes made by man to the environment;

support and relationships;

attitudes;

services, systems and policies.

"Body functions" are the physiological functions of body systems, including psychological functions. The "body structures" are anatomical parts of the body such as organs, limbs and their components. "Activity" is the execution of a task or action by an individual. "Participation" is the involvement of an individual in a life situation. The "environmental factors" are characteristics - of the physical, social and attitudes - that can have an impact on an individual's performance in a given context. The above classification stops at the first levels, but in the OMS document we get to higher levels of detail, extending the above classifications into further sub-classifications. An abbreviation is associated with each classification level.

Thus, for example, the classification "**b11420**" is inserted in the following hierarchy of levels:

Body structures;

**b1** Mental functions;

**b11** Global mental functions;

**b114** Orientation functions;

**b1142** Orientation to the person;

**b11420** Orientation to oneself.

It is associated with the definition "mental functions", which produce the awareness of one's identity. The ICF document covers all aspects of human health, grouping them in the health domain (health domain, which includes seeing, hearing, walking, learning and remembering) and in health-related domains, which include mobility , education, participation in social life and the like).

It is important to clear the field immediately of a misunderstanding: ICF does not only concern people with disabilities, but concerns all people; ICF therefore has a universal use and value. Compared to each of the hundreds of classified entries, each individual can be associated with one or more qualifiers that describe his "functioning".

For the functions and structures of the body the qualifier can assume the values:

|  |
| --- |
| **Table with impairment values** |
| **0-4%** | 0 | No impairment |
| **5-24%** | 1 | Slight impairment |
| **25-49%** | 2 | Moderate impairment |
| **50-95%** | 3 | Serious impairment |
| **96-100%** | 4 | Total impairment |

Similar qualifiers exist for activities, for which restrictions are discussed, and for participation, for which there may be limitations. Finally, environmental factors have barriers. The "positive" classification, which starts from the operation to say if and how much each one departs from it, has the advantage over the ICIDH classification of not having the obligation to specify the causes of an impairment or disability, but only to indicate its effects . It should also be noted that the term "handicap" was abandoned and that the term disability was extended to cover both the restriction of activity and the limitation of participation.

## Pupils with disabilities - by Ministry of Public Education - ITALY

The school integration of pupils with disabilities is a strong point of the Italian school, which wants to be a welcoming community in which all pupils, irrespective of their functional diversity, can realize experiences of individual and social growth. The full inclusion of pupils with disabilities is a goal that the school of autonomy pursues through an intense and articulated design, enhancing the internal professionalism and the resources offered by the territory. MIUR puts in place various support measures to foster integration: support teachers, project funding and integration activities, supportive and curricular teaching staff training, and administrative, technical and auxiliary staff. Advisory and proposing body at national level in the field of school integration and the Observatory for the Integration of Persons with Disabilities.[[1]](#footnote-1)

Who is the teacher for support?

The tutor for support activities is a specialized teacher assigned to the pupil's class with disabilities to support their integration process. It is not therefore the pupil's teacher with disabilities but a professional resource assigned to the class to respond to the major educational needs that his presence entails. The ways to employ this important (but certainly not unique) resource for integration are shared by all involved (school, services, and family) and defined in the Individual Education Plan.

What are the tasks of the class teacher in relation to the integration of pupils with disabilities?

Each teacher has full educational and educational responsibility towards all pupils in his classes, including those with disabilities. It will have to contribute to the programming and achievement of pre-established, educational and / or educational goals, and will therefore be called upon to evaluate the results of its teaching. Since a pupil with disabilities follows personalized and / or individualized learning paths, the actual class teacher's tasks must necessarily be defined within the framework of an Individual Educational Plan. The precise formulation of the goals by each teacher ensures the clear definition of the activities also for the pupil with disabilities and the family and other subjects involved in any form of logistical / organizational support.

What are the responsibilities of the School Executive with regard to the integration of pupils with disabilities?

He is responsible for the organization of integration of pupils with disabilities and supervision over the implementation of what is decided in the Individual Education Plan. The organization includes the allocation of pupils with disabilities to the various classes, scheduling schedules, scheduling of planning meetings, managing all formal documentation and, in general, coordinating the various activities requiring more collaboration subjects. The School Manager also has the task of promoting and encouraging widespread updating and training activities, enhancing projects that promote strategies for enhancing the inclusion process, presiding over the GLH Institute, and addressing the work of individual class / interclass councils, actively engaging families, curing the connection with the various territorial realities, activating specific orientation actions to ensure continuity in taking charge of the subject, taking the necessary steps to identify and remove any barriers architectural.

What are the tasks of the School Collaborators for pupils with disabilities?

School collaborators are entrusted with the so-called "basic care" for pupils with disabilities. Basic assistance means the material assistance to pupils with disabilities within the school, access to and out of areas outside school facilities. Also included are personal care activities, personal hygiene and personal hygiene of a pupil with disabilities. But it is not just a question of "accompanying him to the bathroom". In an inclusive school, basic care is a key part of the process of school integration and activity interconnected with education and teaching. If involved in this way, the school collaborator participates in the educational project and collaborates with the teachers and the family to promote school integration (CM 3390/2001).

What is the role of local authorities?

School integration is also used by other professional figures provided by the Local Authorities (Municipality or Province of residence of the pupil). Application rules may vary according to different regional provisions. "Service Providers" and "Communication Officers" are professional persons appointed by the local Eni, who are present at school to support pupils with disabilities, to enable them to attend the lessons appropriately. The Service Provider figure refers mainly to pupils with physical disabilities and consequent autonomy problems, the Communication Officer deals with pupils with sensory disabilities. However, the organization of these services can be very different in the various regions of Italy. They primarily have the task of allowing the student to enjoy the teaching taught by the teachers. They follow only the specific pupil and have no competence over the rest of the class (in some regions they are also called ad personam assistants). The Assignee's job is also called Specialist Assistance to distinguish it from Basic Assistance entrusted to school collaborators.

What is the Individualized Educational Plan or PEI?

The PEI - Individual Educational Plan describes annually educational and educational interventions for pupils, defining objectives, methods and evaluation criteria. It is an integral part of classroom educational programming and contains:

* aims and educational objectives, and in particular educational, socialization and learning objectives related to the different areas, which can be pursued in the year also in relation to classroom programming;
* work itineraries (specific activities);
* the methods, materials, subsidies and technologies with which to organize the proposal, including the organization of resources (timetables and organization of activities);
* the criteria and the evaluation methods;
* the forms of integration between school and extra-school.

Since the evaluation of pupils with disabilities refers to the PEI, both in terms of objectives and verification methods and criteria, this document should clearly contain all the elements that will then effectively evaluate the outcomes of the didactic action. The PEI is drawn up at the beginning of each school year and is subject to verification. It is jointly drafted by the School and the Services (Psycho-Sociological Equipments) with the collaboration of the Family.

How does the POF (School Supply Plan) take into account pupils with disabilities?

An inclusive school must necessarily take into account the POF formulation of its pupils with disabilities. It must describe what it offers to its users in terms of effective usability for everyone, including pupils with particular difficulties, as well as indicate how the school intervenes to overcome any obstacles to better meet the special educational needs. In particular, it must clearly define how to organize less structured moments such as supplementary activities, educational trips, aggregation spaces, etc. and, in order to avoid the risk of exclusion, it is important to intervene upstream with a suitable inclusive design.

Who should accompany pupils with disabilities in the case of educational trips or other activities (swimming pool, theater ...)?

Even in these cases, the design principle applies. When you decide to organize an educational trip or other initiative for one or more classes, you will have to take into account all the needs: the didactic ones, first and foremost, but also the costs, the security, the times and the distances ... If there is a pupil with disabilities in those classes it will be planned to travel so that he can participate. No standard prescribes how to be cared for or guarded on these occasions: the school, in its autonomy, will set up the most appropriate measures to allow the student to participate in this experience without excessive risks or inconveniences. Surveillance can therefore be entrusted to the support teacher, but also to another teacher, a care provider, a schoolteacher, a mate (high school), a relative or other figure, professional or volunteer, considered appropriate and, of course, available. .

What are the working groups for school integration, GLHI and GLH?

In each school there is a GLHI, Working Group for Handicap of the Institute, established by Law No. 104/92. It is therefore an interinstitutional group, open to all agencies that have expertise in this field: school, parents, ASLs, Local Authorities and, possibly, representatives of the territorial association. In high schools, the presence of students, all in ATA staff, is also important. To be truly an integration tool, it is essential that participation is not limited to those who are directly involved. So not just support teachers, not just parents of pupils with disabilities, not just disabled pupils. It has the task of collaborating with the School Manager to improve the quality of integration by formulating organizational and educational proposals. The GHL expression, the Workgroup on Handicap, refers to each individual pupil and indicates the set of subjects called to define the Functional Dynamic Profile and the PEI, ie all teachers, curriculum and support, and Healthcare Operators, with the collaboration of parents.

What are the local support centers for school counseling?

Territorial network of Permanent Aids Centers with the task of accumulating, retaining and disseminating knowledge (good practices, training courses) and resources (hardware and software) for the teaching of disabled people through the New Technologies. The network is able to effectively support schools in the acquisition and efficient use of new technologies for school integration. Born with the NTD (New Technologies and Disabilities) project, distributed evenly across the Italian territory, offers counseling and training for teachers, parents and students on the technology applied to disabled children. There are currently 100 Support Centers in the national territory. To support the CTS, the Ministry provides training and discussion meetings with regional disability leaders and with the operators of individual Centers. The CTS contact may be contacted both by the School Manager and the Family, as well as by the teachers themselves. The CTS list is available on the website at the page;[[2]](#footnote-2)

Disabled pupils unable to attend

Children with disabilities who are subject to school-leaving, temporarily prevented from attending school for health reasons, are still guaranteed education and school education. To this end, the study administrator, in agreement with the local health units and public and private rehabilitation and rehabilitation centers, with the Ministry of Health and Labor and Social Security, provides for the establishment of the hospitalized children , of ordinary classes such as detached sections of the state school. Those classes may also be admitted to the children accommodated in the hospital, which do not compete in situations of handicap and for which it is established the impossibility of compulsory school attendance for a period not less than thirty days of lesson.[[3]](#footnote-3)

Are students with disabilities a valid academic qualification?

We must distinguish between the first and second cycle of education. In the first cycle, Primary and Secondary Primary School, programming is always valid for promotion to the next class, even when it is completely differentiated since the assessment of pupils with disabilities is always based on their Individualized Educational Plan. This is of course also true at the time of the final Examination Exam (ex-license exam) that the candidate with disabilities will also face by supporting totally different tests, as set out in its PEI. Exceeding these tests will get a valid diploma in all respects, without any mention of the particular path followed. As is apparent from Article 11, paragraph 11 of the O M n. 90/01 ​​only if the pupil of the middle school does not reach the goals of his PEI, which is calibrated solely on the basis of his / her actual skills, he / she does not receive the diploma; in the upper ones, art. 15 of the O M n.90 / 01 distinguishes between simplified and differentiated PEI, a distinction that does not exist for middle school. The situation, in fact, changes in Second Cycle (high school). In this order of school, students with disabilities are guaranteed the frequency, but not the degree of their degree. For them, two distinct paths are possible:

* a curriculum, or for minimum goals, which leads to a regular qualification;
* a differentiator that only allows attendance at the school and, at the end, leads to the issue of a certificate, not a diploma.

What is Differentiated Programming?

In Secondary Secondary School (High School) when the goals of the Individual Educational Plan are significantly different from those of the classroom, the programming is declared differentiated and the student can not get the degree. Except for exceptional situations, differentiated programming applies only in the case of cognitive disabilities. The family is immediately informed of this choice and has the right to oppose; in this case the student will also follow his / her PEI, with the support and any other protection provided, but the evaluation will be done according to the criteria defined for the whole class. By the end of the year, the pupil who follows a differentiated programming is admitted to the next class, but did not achieve the promotion. The scoreboard will be noted that the evaluation was made on the basis of its Individual Educational Plan. No particular note must ever be placed on the boards exposed to the public. At the end of the course there is no diploma but a certificate of training credits.

What are DSA?

Law 8 October 2010, no. 170, recognizes dyslexia, disortography, disgrace and dyscalculia as Specific Disorders of Learning (DSA), assigning to the national education system and universities the task of identifying the most appropriate didactic forms and assessment methods so that pupils and students with DSA can achieve formative success. Specific Learning Disorders Affect Some Specific Skills of Learning in an Enabling Age Behavioral Environment. They are involved in such disorders: the ability to read, to write, to make calculations. Based on the ability affected by the disorder, DSAs have a specific denomination: dyslexia (reading), dysgraphy and disortography (writing), discalculia (calculation). According to currently more accredited research, DSAs are of neurobiological origin; at the same time they have evolutionary matrix and they show themselves as a development aids, editable through targeted interventions. For more information and insights.[[4]](#footnote-4)

What is PDP - Personalized Learning Plan? When does it take place?

In this way, the programming document with which the school defines the interventions it intends to implement in relation to pupils with special needs but not related to disability (in case of disability, as is well known, the programming document is calls PEI, Individualized Learning Plan, very different for content and definition modes). The school may develop such a programming document for all pupils with Special Educational Needs if it deems it necessary. For pupils with DSA, Specific Learning Disorders, a custom programming document (PDP, in fact) is in fact mandatory; Minimum content is indicated in the 2011 Guidelines, as well as the maximum deadlines (within the first trimester). For students with DSA, the class council prepares the Personalized Learning Plan, in the forms considered most appropriate and in times not exceeding the first trimester, for the disciplines involved in the disorder, which should include:

* Personal data
* Type of disturbance
* Individualized didactic activities
* Personalized teaching activities
* Compensatory instruments
* Dispensing measures
* Customized verification and evaluation forms

What are the compensation tools for students with DSA?

Compensatory instruments are educational and technological tools that replace or facilitate the performance required in deficit. Among the most well-known we indicate:

1. the vocal synthesis, which transforms a reading task into a listening task;
2. the recorder, which allows the student or student not to write the lessons of the lesson;
3. spell-writing scripting programs that allow the production of texts that are sufficiently accurate without the fatigue of reading and correcting mistakes;
4. the calculator, which facilitates calculation operations;

Such tools raise the pupil or student with DSA from a performance made difficult by the disorder, while not facilitating the task from a cognitive point of view. The use of these tools is not immediate and teachers - also based on the instructions of the school referent - will care to support their use by pupils and students with DSA.

What are the dispensary measures for pupils with DSA?

Disadvantages are, however, interventions that allow a student or student not to perform certain services that, because of the disorder, are particularly difficult and do not improve learning. For example, it is not helpful to read a long paragraph of a student with dyslexia, because exercise because of the disorder does not improve its performance in reading. Included in the dispensary measures are also programmed questions, the use of the vocabulary, to be able to test on a content significantly disciplinary but reduced or longer times for verifications. The adoption of the dispensation measures should always be evaluated on the basis of the actual incidence of the disorder on the required benefits, so as not to differentiate, in terms of objectives, the learning path of the pupil or student in question.

# 2 - DESCRIPTION OF THE DISABILITIES WE ARE WORKING ON IN THIS PROJECT

## The true Inclusive education - By the operators of Bulgaria.

***The true Inclusive education happens from people and between people. It’s not tied to any documents, requirements and rules coming from outside. If someone who works in school has a desire to accept a child, to make room for his or her personality, respect the right to be different, no one can stop this human connection. No laws can make someone accept and respect the difference of the other.***

Long before children start talking, they are skilled at using eye contact, facial expression and nonverbal gestures to communicate with other people. They also are able to discriminate speech sounds from an early age. Vocabulary learning builds on the child’s knowledge about objects, actions, locations, properties, and stages gained as a result of sensorimotor development. Early word combinations allow children to express semantic relationships between these various referents. During the period from 2-4 years of age, children move from expressing their ideas in simple telegraphic speech to being able to ask questions, use negation, talk about past and future events and describe complicated situations using sentences constructed according to complex grammatical rules. (Leslie Rescorla, Jennifer Mirak, 1997)

The children with special needs have some difficulties in the areas described above due to various syndromes or disabilities.

Of course, there are general guidelines for work and recommendations, but it is good each case to be considered by the team where the child's teacher is involved as he is the holder of valuable information. In our practice with the children with special needs, we can outline several pillars, namely: *teamwork, individual approach and parental support.*

**Hyperactivity**

Nowadays, the term "hyperactivity" is widely used by numerous professionals in the educational field and is widely used into the everyday life as well as among the wider audience. Many researchers claim that such a diagnosis does not exist and that hyperactivity is a symptom with different status in different scenarios.

The onset of Hyperactivity and Hyperactivity Disorder begins at the age of 3-4 years. Their full development and clinical appearance appear at primary school age. It is usually against the backdrop of well-developed intelligence, but it can become a prerequisite for future learning difficulties.

**Symptoms:**

a) often waving hands and moving around or spinning in the chair;

b) leaves his / her place in the classroom or in another situation where he / she is required to stay in one place;

c) often runs and climbs in inappropriate places;

d) often has difficulty playing or enjoying quiet and relaxing games;

e) is often "on the go";

f) often speaks a lot;

Impulsiveness:

a) often explodes in response to a question that has not yet been completed;

b) often experiences difficulties while waiting in line;

c) often interrupts others or engages in inappropriate behavior.

**2. Anamnesis and observation:**

Scientists still do not have a definite answer to etiology, and that raises great questions about the development of therapeutic strategies. Because of this, it is necessary to collect the following information:

1. Discuss the problems that may arise / have already occurred in the course of child development:

- “Motor functions” development;

- Language

- Intellect;

- Academic success;

- Emotional and social functioning.

2. Determine whether the symptoms are not due to stress or family dysfunction.

3. Explore the child's relationship with peers and their leisure time behavior.

4. Explore child-parent relationship as well as the right ways of education and the relevant reactions of the child.

5. A clinical interview with the child should not be conducted under the age of 9-10 year as the children still do not have a critical perception of their behavior, therefore observation of the child is crucial.

6. Interview with the teachers of the child through a questionnaire, which can be completed by the parents as well.

***This approach to assessing mental development with all the history is done for every child with special needs under a procedure approved from Ministry of education through standardized methodologies.***

**Attention deficit**

1. **Symptoms:**
2. Often fails to focus on the details or makes errors at school or during other activities;

b)Experiences difficulties in retaining attention on tasks or activities;

c) Does not seem to listen to what is spoken to him;

d) Does not follow the instructions and cannot finish the task, where the main reason is not because of opposition or misunderstanding of the instructions;

e) Avoids or disapproves with tasks that require mental effort;

f) Loses things needed to perform tasks and activities (e.g. pencils, books, tools, toys, etc.);

g) Gets easily distracted by surrounding incentives;

h) Forgets to carry out daily activities;

i) Experiences difficulties to organize his/ her tasks and activities.

In general, the treatment for ADHD should be strictly individualized according to the specific symptoms of each child, intellectual and training abilities, personality characteristics and family support.

**3. The main objectives of the ADHD therapeutic strategies are:**

- To reduce overactivity and impulsivity.

- To modify the child’s behavior at home, at school, and among friends. In other words, to increase the ability to pay attention, to improve the concentration, to improve the learning style and to enhance the academic achievements.

- The formation of new social skills.

- To correct communicative disorders.

**4. Guidelines:**

a) A quiet working environment should be ensured. Noise and other too strong stimuli such as music, visual stimuli and other are increasing the main symptom of ADHD.

b) An often change of the type of the activities is required in order the working process to be efficient. The use of different colors and shapes is recommended in order to boost the incentive for effective work.

c) It is recommended to make things visually and tactilely more appealing in order to impress the children and to attract their attention as well as to motivate them to engage with them longer.

**5. Strategies in emerging behavior:**

It depends on what difficulties has the pupil but usually we call psychologist or someone from the team to deal with. Sometimes the child needs to go outside and calm down. We based on children needs and try to use their own resources in live together context, always talk for emotions.

**Autistic spectrum disorder**

1. **Two groups of symptoms from DSM-V: The revised 5 criteria:**
2. Persistant deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history:
* Deficits in social-emotional reciprocity, ranging from abnormal social approach and failure of normal back-and-forth conversation to reduced sharing of interests, emotions or affect to failure to initiate or respond to social interactions.
* Deficits in nonverbal communicative behaviors used for social interaction, ranging from poorly integrated verbal and nonverbal communication to abnormalities in eye contact and body language or deficits in understanding and use of gestures to a total lack of facial expressions and nonverbal communication.
* Deficits in developing, maintaining and understanding relationships, ranging from difficulties adjusting behavior to suit various social contexts to difficulties in sharing imaginative play or in making friends to absence of interest in peers.
1. Restricted, repetitive patterns of behavior, interests or activities as manifested by at least two of the following currently or by history:
* Stereotyped or repetitive motor movements, use of object or speech (e.g. simple motor stereotypies, lining up toys, or flipping objects, echolalia, idiosyncratic phrases).
* Insistence of sameness, inflexible adherence of routines or ritualized patterns, greeting rituals, need to take same rout or same food every day.
* Highly restricted, fixated interests that are abnormal intensity or focus.
* Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspect of environment (e.g. apparent indifference of pain/temperature, adverse response to specific sound or textures, excessive smelling or touching of objects, visual fascination with light or movement).

*Specify current severity: Severity is based on social communication impairments and restricted repetitive patterns of behavior.*

1. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities or may be masked by learned strategies in later life).
2. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
3. These disturbances are not better explained by intellectual disability or global developmental delay.
4. **Severity levels:**

*Level 1 - Restricted, repetitive behaviors - requiring support*

A person who is able to speak in full sentences but whose to- and fro- conversation with other fails and whose attempts to make friends are odd and typically unsuccessful. Inflexibility of behavior causes significant interference with functioning in one or more contexts. They have difficulty in switching between activities. There are problems in organization and planning.

*Level 2 – Social communication – requiring substantial support*

There are deficits in verbal and nonverbal social communication skills. They have limited initiation of social interactions and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests and who has odd nonverbal communication.

Inflexibility of behavior, difficulty in coping with change and repetitive behaviors appear frequently enough to be obvious to casual observer and interfere with functioning in a variety of contexts. They have distress and difficulty in changing focus or action.

*Level 3 – Severity level – requiring very substantial support.*

Severe deficits in verbal and nonverbal communication skills cause severe impairments in functioning, very limited initiation of social interactions and minimum response to social overtures. For example, a person with few words of intelligible speech, who rarely initiate interaction.

Inflexibility of behavior, extreme difficulty coping with change or other repetitive behaviors markedly interfere in functioning in all spheres. They have great distress and difficulty changing focus or action.

 **How to deal with autism?**

Dealing with autism is a long process. First of all we try to reach some *emotional contact* with pupil and to build trust. It could take a long time but the purpose here is acceptance and set to children needs and resources. We use different activities to develop contact, based on pupils’s interest and resources – drawing, music and singing, visual materials, sensory programme. Gradually we include pupils in groups as work together here is important. On second stage we try to develop verbal activity using cards and visual materials while giving sense of what we see and do. On the third stage we can develop reading and writing.

*In our work we accent on playing therapy and work together as it is possible for every child.*

In addition, evidence from numerous sources suggests that the social and linguistic environments of autistic children, most of whom have *active, loving and determined parents and teachers*, can be quite different from those of other children. (Konstantareas, Zajdemann, Homatidis & McCabe, 1988; Siller & Sigman, 2002).

**Intellectual disability**

In the upcoming fifth edition of The diagnostic and Statistical manual of Mental Disorders (DSM-V), the diagnosis of *intellectual disability* (intellectual developmental disorder) is revised from the DSM-IV diagnosis of *mental retardation*. The significant changes address what the disorder is called, its impact on a person’s functioning and criteria improvements ***to encourage more comprehensive patient assessment.***

Intelligence is common feature that brings together many abilities. These abilities develop relatively evenly but in cases of intellectual disability there may be significant discrepancies which impact and individual’s adaptive functioning. There are three domains determine how well an individual copes with everyday tasks:

1. ***the conceptual domain*** includes skills in language, reading, writing, math, reasoning, knowledge and memory;
2. ***the social domain*** refers to empathy, social judgment, interpersonal communication skills, ability to make and retain friendship and similar capacities;
3. ***the practical domain*** centers on self-management in area such as personal care, job responsibilities, money management, recreation and organizing school and work tasks.

While intellectual disability does not have a specific age requirement, an individual symptoms must been during the developmental period and are diagnosed based on the severity of deficits in adaptive functioning.

*The disorder is considered chronic and often co-occurs with other mental conditions like depression, attention-deficit/hyperactivity disorder and autism spectrum disorder.*

***DSM-V emphasizes the need to use both clinical assessment and standardized testing of intelligence when diagnosing intellectual disability, with the severity of impairment based on adaptive functioning rather than IQ test scores alone.*** By removing an IQ test scores from the diagnostic criteria, but still including them in the text description of intellectual disability, ***DSM-V ensures that they are not overemphasized as the defining factor of a person’s overall ability***. This is especially important in the development of individual plan.

In DSM-V, intellectual disability is considered to be approximately two standard deviations or more below the population, which equals an IQ score of about 70 or below.

**Therapy:**

The main here is speech therapy while we improve development of cognitive sphere together with psychologist and special teacher, ergotherapy, psychomotor therapy and art therapy.

**Learning difficulties**

***Usually learning difficulties are diagnosed at the end of the first grade. Thus, in Kindergarten we discuss markers of mental development that could be predictors for dyslexia.***

Dislexia is defined as various patterns of difficulties in processing of information that restrict the development of literacy and lead to mismatch between the expected and real academic achievements. (Reid, 1998).

There are some prior difficulties noticeable – visual, coordination disturbances, attention specificities, language developmental disorders. The main predictor is slow language processing in phonology (perception and production of sounds to form words), morphology, syntax, semantics (words and their meanings), pragmatics (communicative use of language in social context). The morphology and syntax are about grammatical system – form the plural, awareness of rhymes, to form words and combining them into sentences by rules for indicating distinctions such as tense, case and person.

1. **Identity criteria for dyslexia in early and pre-school age are:**
2. Delayed communication skills;
3. Delayed learning of words followed by intensive language development;
4. Inversions of speech sounds and sylabells in words;
5. Difficulties in verbal and manual classification of objects;
6. Distorted articulation in multi-word words;
7. Difficulties in understanding of questions – when, where, how, with whom, etc.;
8. Understanding metaphors;
9. Recognizing more objects at the same time;
10. Difficulties in named objects and finding the right words;
11. Deficit in the use of morphological categories;
12. Difficulties in understanding and producing structured set of sentences.[[5]](#footnote-5)
13. **Therapy:**

In our practice we apply an *universal therapy* to develop the cognitive sphere – developing all kinds of gnosis and praxis. Gnosis is the ability of the brain to recognize previously learned information such as objects, persons or places collected from our senses. Thus, there are different types of gnosis, one for each sensory modality and gnosis which combines different sensory modalities. Simple gnostic processes – visual, auditory, tactile, olfactory and gustatory and complex – body schema, rhythm, color gnosis, for shape and size and time orientation – the days of the week, months, seasons, clock and time-table. Praxis refers to learned motor activity. In other words praxis is the generation of volitional movement for the performance of a particular action or towards achieving a goal. Generally we develop visual-motor coordination and graffo-motor skills. After 4-5 years of age speech therapy include phonological awareness and rhymes.

***Psychological therapy in all 5 types of difficulties include development of cognitive sphere but also imaginative play, making stories and fairytales according to child’s capacity and age, art activities and psychomotor activities where the individual is able to construct and reveal something from his or her own subjectivity or to build delimitation between the subject and the other one.***

## Mental learning disability - By Turkish operators

Mental learning disability; it adversely affects the educational performance and social adaptation skills of the individual due to the insufficiency of mental development. The mental functions and social behaviors of children with intellectual learning disabilities are inadequate and inadequate according to their peers. These children learn late and power according to their peers and often have difficulties in complying with the rules of the class or the society. Mental learning disabilities may be classified as mild, moderate, severe and very severe mental learning disabilities according to the severity of mental functioning and lack of social adaptation skills. Most of the children with mild to moderate learning disabilities are not noticeable until they do not start school, mainly because of their mental, social and physical development. Children with severe and very severe levels of learning disabilities can be recognized previously because they show significant differences from their peers in terms of their mental, social and physical development.

It is of vital importance for the mentally, socially and physically development of individuals with intellectual learning disabilities to take necessary educational measures in early diagnosis and education environments, and to support them to use their existing potentials with the necessary social support. With the early diagnosis and taking necessary educational measures, it is seen that these children can improve their mental performance, social adaptation skills and physical development and make their lives easier.

Mild learning disability; Due to the limited deficiency of the individual's mental functions and conceptual, social and practical adaptation skills, he / she needs limited support education services and special arrangements during the education period.

Mild intellectual disability has the most common rate of mental disability among others. Nearly 90% of the children with mental retardation are children with mild disabilities. When these children are compared with their peers, their similarities are much more than their differences. The intelligence sections of the individuals in this group are between 50 and 69. They can have intelligence at the age of 8ya12 according to the degree of retardation. They can carry out academic studies at the level of primary education.

In the educational environment, give the child tasks he can accomplish, ask questions he can answer correctly. Support by assisting to perform the task as needed. Do not leave the child unattended at points where he failed. Let your child succeed and enjoy a successful sense of success.

Support the child by rewarding the child's correct answers and behaviors. This reward may be as concrete as giving food to a child or touching it, caressing its hair.

Help the child to transfer information from one stance to another by improving the ability of transferring information to the child by teaching the situation of the same concepts in various situations and relationships.

Children with mental disabilities have various problems in transferring their learning from short-term memory to long-term memory. Therefore, they may soon forget a topic they have learned. To prevent this situation, try to avoid forgetfulness by repeating the subjects or behaviors learned.

These children have difficulty learning abstract concepts. It will be useful to use teaching methods such as observation experiment and modeling to increase the efficiency of learning.

Make them learn by doing and living. It will be useful to use drama and play methods in acquiring basic skills and learning the school rules.

Benefit from concrete materials when teaching and understanding the mentally handicapped child because they are weaker than normal children.

Emotions and thoughts that are difficult to express these children to express their feelings and thoughts should be prepared in an appropriate environment. To enable them to socialize, they should be encouraged to participate in class activities and social-cultural activities at school. However, duties and responsibilities that this class cannot achieve by taking into account the performance of the child should not be given. Otherwise, the child will lose his self-confidence.

## ADHD - By Turkish operators

Children with ADHD need environments which are in order. They need to be reminded, to make rehearsals and repetitions, to be guided and have restrictions.

Rules should be written and hung to a place they always can see. Instructions should be often repeated. Try to catch their eyes, this will help them to focus attention.

Such children should be sitted near to their teachers. By this way, teachers will be able to draw their attention.

Teachers and parents should be careful that they obey a programme and help them to write what they should do after school. By doing this you can stop the “delay” which is one of the most important characteristics of ADHD children.

You can draw their attention by leaving them out of the class for some time org ive some other duties to do. Homeworks should be with high quality. Such children can learn much knowledge, but can’t do many homeworks. They should be controlled often, what they have learnt should be checked. So, they will be encouraged.

Big projects should be diveded into small pieces. Otherwise, they will be discouraged. Because they will have the feeling that they will never be able to finish that work. Successful works of these children should be seen and appreciated. These children face many failures that they need any positive reactions.

ADHD children’s the biggest problem is being unable to remember. Clues should be given to them so that their memory will streghten and help them to remember.

## Special needs – by 1st Special Nursery school of Patras

**Hyperactivity**

Hyperactivity is a state of being unusually or abnormally active. Hyperactivity is often difficult for people around the hyperactive person, such as teachers, employers, and parents. Hyperactive people often become anxious or depressed because of their condition and how people respond to them.

People who are hyperactive may develop other problems due to their inability to stay still or concentrate. For example, hyperactivity may lead to difficulties at school or work, and may strain relationships with friends and family. It can lead to accidents and injuries, and it increases the risk of alcohol and drug abuse.

Hyperactivity has many different characteristics, including:

* constant movement
* aggressive behavior
* impulsive behavior
* being easily distracted

Hyperactivity is often a symptom of another underlying cause, such as varying mental diseases and medical.

One of the main disorders associated with hyperactivity is attention deficit hyperactivity disorder, or ADHD. ADHD is a disorder that causes you to become overactive, inattentive, and impulsive. This condition is usually diagnosed at a young age, but some people experience ADHD as adults.

Hyperactivity is treatable. For the best results, early detection and early treatment are required.

**What Causes Hyperactivity?**

Hyperactivity can be caused by mental and physical disorders. The most common are:

* ADHD
* hyperthyroidism, or having too much thyroid hormone
* brain disorders
* nervous system disorders
* psychological disorders

**Recognizing the Signs of Hyperactivity**

In children, hyperactivity may lead to difficulty concentrating in school. They may also display impulsive behaviors such as:

* talking out of turn
* blurting things out
* hitting other students
* being overactive

Adults who display hyperactivity may display the following:

* difficulty concentrating at work
* short attention span
* difficulty remembering names, numbers, or bits of information

You may develop some anxiety or depression if you are distressed about your condition. Adults who have hyperactivity probably displayed these symptoms as children

**Lack of Attention**

Pupils who suffer with an inability to concentration will find their daily school life a challenge. Many of these pupils are wrongly labelled as ‘naughty’ or children with behavioural problems, with the real reason being down to them suffering from a disorder that affects their concentration levels. Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) are two of the most common disorders with these symptoms and can, at times, reach fever pitch unexpectedly causing pupils to break school rules. This can be both frustrating and upsetting for the pupil and will need to be dealt with in a calm and collected manner with understanding and care. This lack of concentration can affect many parts of school life and with specialist help from teaching staff pupils can learn to overcome some of the struggles that come with having an attention deficit disorder. Sitting for long periods of time is a challenge for most pupils but add in the inability to concentrate and this becomes a greater challenge. Pupils who suffer from a lack of concentration are seen daydreaming when the rest of the class is paying attention missing out on valuable teaching time. As a result they may fall behind and become less motivated, with their confidence and self-esteem also being affected.

For primary school pupils, their lack of concentration can be easier to deal with, and the help they get at this stage will benefit them in their future learning. If they are required to sit for a long period of time to complete a piece of work, allowing them the opportunity to get out of their seat after a set period can reduce their chances of daydreaming or frustration creeping in. If they can achieve this with little disruption to the rest of the class, praise must be forthcoming. A gold star or a special merit at the end of the week for good behaviour will make such a difference to these struggling pupils. This will encourage further good behaviour and a pattern will begin to build up. Work consisting of large amounts of words should be replaced by a mixture of words, images and diagrams, with activities kept short and interesting. This allows struggling pupils to participate in class and help keep their focus.

Unless there is a necessary need to remove a pupil who is unable to concentrate from class, they should remain amongst their classmates and where possible teamed up with pupils they will learn from.

Older pupils who lack concentration skills can behave very differently when in class. They become frustrated at their inability to focus like their classmates or find the lesson just doesn’t hold their attention. These pupils can become disruptive, get out of their seats and try to distract the other pupils, giving them the label ‘nuisance’ or ‘irritating.’ The best way to deal with this is not to completely exclude this pupil as that will only alienate them from the rest of the class and could possibly lead to further problems. Setting aside a workspace away from the class and allowing them to work from a prepared worksheet with the aid of a teaching assistant or possibly another pupil who they have been known to work well with. However, if their behaviour goes beyond a mere lack of concentration, then removing them from the class will be the only option. Sometimes a brief spell away from their normal environment can be beneficial. Most secondary schools have a SEN support area where pupils can be sent for one-to-one teaching and help. This is known to work extremely well and allows the struggling pupil to work at their own pace. Be aware of what provisions your school has in place for pupils with these types of struggles.

Plan ahead for any potential difficult situations that may occur and how you will help to limit them. If you are aware that a lesson will require pupils to take notes or need to follow particular set of instructions, and you feel that one or two pupils will find the need to concentration difficult, draw up a small hand-out. You may find that not only pupils who suffer from a lack of concentration who will benefit from this hand-out, pupils who find writing at speed difficult, or have poor hand/eye co-ordination or possibly suffer from ear/eye problems will also find this hand-out extremely helpful.

**Autism**

Autism is a complex neurobehavioral condition that includes impairments in social interaction and developmental language and communication skills combined with rigid, repetitive behaviors. Because of the range of symptoms, this condition is now called autism spectrum disorder (ASD). It covers a large spectrum of symptoms, skills, and levels of impairment. ASD ranges in severity from a handicap that somewhat limits an otherwise normal life to a devastating disability that may require institutional care.

Children with autism have trouble communicating. They have trouble understanding what other people think and feel. This makes it very hard for them to express themselves either with words or through gestures, facial expressions, and touch.

A child with ASD who is very sensitive may be greatly troubled -- sometimes even pained -- by sounds, touches, smells, or sights that seem normal to others.

Children who are autistic may have repetitive, stereotyped body movements such as rocking, pacing, or hand flapping. They may have unusual responses to people, attachments to objects, resistance to change in their routines, or aggressive or self-injurious behavior. At times they may seem not to notice people, objects, or activities in their surroundings. Some children with autism may also develop seizures. And in some cases, those seizures may not occur until adolescence.

Some people with autism are cognitively impaired to a degree. In contrast to more typical cognitive impairment, which is characterized by relatively even delays in all areas of development, people with autism show uneven skill development. They may have problems in certain areas, especially the ability to communicate and relate to others. But they may have unusually developed skills in other areas, such as drawing, creating music, solving math problems, or memorizing facts. For this reason, they may test higher -- perhaps even in the average or above-average range -- on nonverbal intelligence tests.

Symptoms of autism typically appears during the first three years of life. Some children show signs from birth. Others seem to develop normally at first, only to slip suddenly into symptoms when they are 18 to 36 months old. However, it is now recognized that some individuals may not show symptoms of a communication disorder until demands of the environment exceed their capabilities. Autism is four times more common in boys than in girls. It knows no racial, ethnic, or social boundaries. Family income, lifestyle, or educational levels do not affect a child's chance of being autistic.

Autism is said to be increasing; however, it is not entirely clear whether the increase is related to changes in how it is diagnosed or whether it is a true increase in the incidence of the disease.

Autism is just one syndrome that now falls under the heading of autism spectrum disorders.  Previous disorders that are now classified under the umbrella diagnosis of  ASD or a social communication disorder include:

* **Autistic disorder.** This is what most people think of when they hear the word "autism." It refers to problems with social interactions, communication, and imaginative play in children younger than 3 years.
* **Asperger's** **syndrome.** These children don't have a problem with language -- in fact, they tend to score in the average or above-average range on intelligence tests. But they have the same social problems and limited scope of interests as children with autistic disorder.
* **Pervasive developmental disorder or PDD -- also known as atypical autism.** This is a kind of catch-all category for children who have some autistic behaviors but who don't fit into other categories.
* **Childhood disintegrative disorder.** These children develop normally for at least two years and then lose some or most of their communication and social skills. This is an extremely rare disorder and its existence as a separate condition is a matter of debate among many mental health professionals.

**Rett syndrome**  previously fell under ASD spectrum but it is now confirmed that Rett’s cause is genetic. It no longer falls under ASD guidelines. Children with Rett syndrome, primarily girls, start developing normally but then begin losing their communication and social skills. Beginning at the age of 1 to 4 years, repetitive hand movements replace purposeful use of the hands. Children with Rett syndrome are usually severely cognitively impaired.

**What Causes Autism?**

Because autism runs in families, most researchers think that certain combinations of genes may predispose a child to autism. But there are risk factors that increase the chance of having a child with autism.

Advanced age of the mother or the father increases the chance of an autistic child.

When a pregnant woman is exposed to certain drugs or chemicals, her child is more likely to be autistic. These risk factors include the use of alcohol, maternal metabolic conditions such as diabetes and obesity, and the use of antiseizure drugs during pregnancy. In some cases, autism has been linked to untreated phenylketonuria (called PKU, an inborn metabolic disorder caused by the absence of an enzyme) and rubella (German measles).

Although sometimes cited as a cause of autism, there is no evidence that vaccinations cause autism.

Exactly why autism happens isn't clear. Research suggests that it may arise from abnormalities in parts of the brain that interpret sensory input and process language.

Researchers have no evidence that a child's psychological environment -- such as how caregivers treat the child -- causes autism.

**Cerebral palsy**

Cerebral palsy is a disorder of movement, muscle tone or posture that is caused by damage that occurs to the immature, developing brain, most often before birth.

Signs and symptoms appear during infancy or preschool years. In general, cerebral palsy causes impaired movement associated with abnormal reflexes, floppiness or rigidity of the limbs and trunk, abnormal posture, involuntary movements, unsteady walking, or some combination of these.

People with cerebral palsy may have problems swallowing and commonly have eye muscle imbalance, in which the eyes don't focus on the same object. People with cerebral palsy also may suffer reduced range of motion at various joints of their bodies due to muscle stiffness.

Cerebral palsy's effect on functional abilities varies greatly. Some affected people can walk while others can't. Some people show normal or near-normal intellectual capacity, but others may have intellectual disabilities. Epilepsy, blindness or deafness also may be present.

**Symptoms**

Signs and symptoms can vary greatly. Movement and coordination problems associated with cerebral palsy may include:

* Variations in muscle tone, such as being either too stiff or too floppy
* Stiff muscles and exaggerated reflexes (spasticity)
* Stiff muscles with normal reflexes (rigidity)
* Lack of muscle coordination (ataxia)
* Tremors or involuntary movements
* Slow, writhing movements (athetosis)
* Delays in reaching motor skills milestones, such as pushing up on arms, sitting up alone or crawling
* Favoring one side of the body, such as reaching with only one hand or dragging a leg while crawling
* Difficulty walking, such as walking on toes, a crouched gait, a scissors-like gait with knees crossing, a wide gait or an asymmetrical gait
* Excessive drooling or problems with swallowing
* Difficulty with sucking or eating
* Delays in speech development or difficulty speaking
* Difficulty with precise motions, such as picking up a crayon or spoon
* Seizures

The disability associated with cerebral palsy may be limited primarily to one limb or one side of the body, or it may affect the whole body. The brain disorder causing cerebral palsy doesn't change with time, so the symptoms usually don't worsen with age. However, muscle shortening and muscle rigidity may worsen if not treated aggressively.

Brain abnormalities associated with cerebral palsy also may contribute to other neurological problems. People with cerebral palsy may also have:

* Difficulty with vision and hearing
* Intellectual disabilities
* Seizures
* Abnormal touch or pain perceptions
* Oral diseases
* Mental health (psychiatric) conditions
* Urinary incontinence

**Causes**

Cerebral palsy is caused by an abnormality or disruption in brain development, usually before a child is born. In many cases, the exact trigger isn't known. Factors that may lead to problems with brain development include:

* **Mutations** in genes that lead to abnormal brain development
* **Maternal infections** that affect the developing fetus
* **Fetal stroke,** a disruption of blood supply to the developing brain
* **Infant infections** that cause inflammation in or around the brain
* **Traumatic head injury** to an infant from a motor vehicle accident or fall
* **Lack of oxygen** to the brain (asphyxia) related to difficult labor or delivery, although birth-related asphyxia is much less commonly a cause than historically thought

**Risk factors**

A number of factors are associated with an increased risk of cerebral palsy.

#### Maternal health

Certain infections or health problems during pregnancy can significantly increase cerebral palsy risk to the baby. Infections of particular concern include:

* **German measles (rubella).** Rubella is a viral infection that can cause serious birth defects. It can be prevented with a vaccine.
* **Chickenpox (varicella).** Chickenpox is a contagious viral infection that causes itching and rashes, and it can cause pregnancy complications. It too can be prevented with a vaccine.
* **Cytomegalovirus.** Cytomegalovirus is a common virus that causes flu-like symptoms and may lead to birth defects if a mother experiences her first active infection during pregnancy.
* **Herpes.** Herpes infection can be passed from mother to child during pregnancy, affecting the womb and placenta. Inflammation triggered by infection may then damage the unborn baby's developing nervous system.
* **Toxoplasmosis.** Toxoplasmosis is an infection caused by a parasite found in contaminated food, soil and the feces of infected cats.
* **Syphilis.** Syphilis is a sexually transmitted bacterial infection.
* **Exposure to toxins.** Exposure to toxins, such as methyl mercury, can increase the risk of birth defects.
* **Zika virus infection.** Infants for whom maternal Zika infection causes microcephaly can develop cerebral palsy.
* **Other conditions.** Other conditions may increase the risk of cerebral palsy, such as thyroid problems, intellectual disabilities or seizures.

#### Infant illness

Illnesses in a newborn baby that can greatly increase the risk of cerebral palsy include:

* **Bacterial meningitis.** This bacterial infection causes inflammation in the membranes surrounding the brain and spinal cord.
* **Viral encephalitis.** This viral infection similarly causes inflammation in the membranes surrounding the brain and spinal cord.
* **Severe or untreated jaundice.** Jaundice appears as a yellowing of the skin. The condition occurs when certain byproducts of "used" blood cells aren't filtered from the bloodstream.

**Other factors of pregnancy and birth**

While the potential contribution from each is limited, additional pregnancy or birth factors associated with increased cerebral palsy risk include:

* **Breech births.** Babies with cerebral palsy are more likely to be in a feet-first position (breech presentation) at the beginning of labor rather than headfirst.
* **Complicated labor and delivery.** Babies who exhibit vascular or respiratory problems during labor and delivery may have existing brain damage or abnormalities.
* **Low birth weight.** Babies who weigh less than 5.5 pounds (2.5 kilograms) are at higher risk of developing cerebral palsy. This risk increases as birth weight drops.
* **Multiple babies.** Cerebral palsy risk increases with the number of babies sharing the uterus. If one or more of the babies die, the chance that the survivors may have cerebral palsy increases.
* **Premature birth.** A normal pregnancy lasts 40 weeks. Babies born fewer than 37 weeks into the pregnancy are at higher risk of cerebral palsy. The earlier a baby is born, the greater the cerebral palsy risk.
* **Rh blood type incompatibility between mother and child.** If a mother's Rh blood type doesn't match her baby's, her immune system may not tolerate the developing baby's blood type and her body may begin to produce antibodies to attack and kill her baby's blood cells, which can cause brain damage.

**Complications**

Muscle weakness, muscle spasticity and coordination problems can contribute to a number of complications either during childhood or later during adulthood, including:

* **Contracture.** Contracture is muscle tissue shortening due to severe muscle tightening (spasticity). Contracture can inhibit bone growth, cause bones to bend, and result in joint deformities, dislocation or partial dislocation.
* **Malnutrition.** Swallowing or feeding problems can make it difficult for someone who has cerebral palsy, particularly an infant, to get enough nutrition. This may cause impaired growth and weaker bones. Some children may need a feeding tube for adequate nutrition.
* **Mental health conditions.** People with cerebral palsy may have mental health (psychiatric) conditions, such as depression. Social isolation and the challenges of coping with disabilities can contribute to depression.
* **Lung disease.** People with cerebral palsy may develop lung disease and breathing disorders.
* **Neurological conditions.** People with cerebral palsy may be more likely to develop movement disorders or worsened neurological symptoms over time.
* **Osteoarthritis.** Pressure on joints or abnormal alignment of joints from muscle spasticity may lead to the early onset of painful degenerative bone disease (osteoarthritis).
* **Osteopenia.** Fractures due to low bone density (osteopenia) can stem from several common factors such as lack of mobility, nutritional shortcomings and antiepileptic drug use.
* **Eye muscle imbalance.** This can affect visual fixation and tracking; an eye specialist should evaluate suspected imbalances.

**Prevention**

Most cases of cerebral palsy can't be prevented, but you can lessen risks. If you're pregnant or planning to become pregnant, you can take these steps to keep healthy and minimize pregnancy complications:

* **Make sure you're vaccinated.** Vaccination against diseases such as rubella may prevent an infection that could cause fetal brain damage.
* **Take care of yourself.** The healthier you are heading into a pregnancy, the less likely you'll be to develop an infection that may result in cerebral palsy.
* **Seek early and continuous prenatal care.** Regular visits to your doctor during your pregnancy are a good way to reduce health risks to you and your unborn baby. Seeing your doctor regularly can help prevent premature birth, low birth weight and infections.
* **Practice good child safety.** Prevent head injuries by providing your child with a car seat, bicycle helmet, safety rails on beds and appropriate supervision.

**Low level mental disability**

Once called mental retardation, is characterized by below-average intelligence or mental ability and a lack of skills necessary for day-to-day living. People with intellectual disabilities can and do learn new skills, but they learn them more slowly. There are varying degrees of intellectual disability, from mild to profound.

**What is intellectual disability?**

Someone with intellectual disability has limitations in two areas. These areas are:

* **Intellectual functioning.**Also known as IQ, this refers to a person’s ability to learn, reason, make decisions, and solve problems.
* **Adaptive behaviors.** These are skills necessary for day-to-day life, such as being able to communicate effectively, interact with others, and take care of oneself.

IQ (intelligence quotient) is measured by an IQ test. The average IQ is 100, with the majority of people scoring between 85 and 115. A person is considered intellectually disabled if he or she has an IQ of less than 70 to 75.

To measure a child’s adaptive behaviors, a specialist will observe the child’s skills and compare them to other children of the same age. Things that may be observed include how well the child can feed or dress himself or herself; how well the child is able to communicate with and understand others; and how the child interacts with family, friends, and other children of the same age.

Intellectual disability is thought to affect about 1% of the population. Of those affected, 85% have mild intellectual disability. This means they are just a little slower than average to learn new information or skills. With the right support, most will be able to live independently as adults.

**What are the signs of intellectual disability in children?**

There are many different signs of intellectual disability in children. Signs may appear during infancy, or they may not be noticeable until a child reaches school age. It often depends on the severity of the disability. Some of the most common signs of intellectual disability are:

* Rolling over, sitting up, crawling, or walking late
* Talking late or having trouble with talking
* Slow to master things like potty training, dressing, and feeding himself or herself
* Difficulty remembering things
* Inability to connect actions with consequences
* Behavior problems such as explosive tantrums
* Difficulty with problem-solving or logical thinking

In children with severe or profound intellectual disability, there may be other health problems as well. These problems may include seizures, mood disorders (anxiety, autism, etc.), motor skills impairment, vision problems, or hearing problems.

**What causes intellectual disability?**

Anytime something interferes with normal brain development, intellectual disability can result. However, a specific cause for intellectual disability can only be pinpointed about a third of the time.

The most common causes of intellectual disability are:

* **Genetic conditions.** These include things like Down syndrome and fragile X syndrome.
* **Problems during pregnancy.** Things that can interfere with fetal brain development include alcohol or drug use, malnutrition, certain infections, or preeclampsia.
* **Problems during childbirth.** Intellectual disability may result if a baby is deprived of oxygen during childbirth or born extremely premature.
* **Illness or injury.** Infections like meningitis, whooping cough, or the measles can lead to intellectual disability. Severe head injury, near-drowning, extreme malnutrition, infections in the brain, exposure to toxic substances such as lead, and severe neglect or abuse can also cause it.
* **None of the above**. In two-thirds of all children who have intellectual disability, the cause is unknown.

 **Can intellectual disability be prevented?**

Certain causes of intellectual disability are preventable. The most common of these is fetal alcohol syndrome. Pregnant women shouldn’t drink alcohol. Getting proper prenatal care, taking a prenatal vitamin, and getting vaccinated against certain infectious diseases can also lower the risk that your child will be born with intellectual disabilities.

In families with a history of genetic disorders, genetic testing may be recommended before conception.

Certain tests, such as ultrasound and amniocentesis, can also be performed during pregnancy to look for problems associated with intellectual disability. Although these tests may identify problems before birth, they cannot correct them.

**How is intellectual disability diagnosed?**

Intellectual disability may be suspected for many different reasons. If a baby has physical abnormalities that suggest a genetic or metabolic disorder, a variety of tests may be done to confirm the diagnosis. These include bloodtests, urine tests, imaging tests to look for structural problems in the brain, or electroencephalogram (EEG) to look for evidence of seizures.

In children with developmental delays, the doctor will perform tests to rule out other problems, including hearing problems and certain neurological disorders. If no other cause can be found for the delays, the child will be referred for formal testing.

Three things factor into the diagnosis of intellectual disability: interviews with the parents, observation of the child, and testing of intelligence and adaptive behaviors. A child is considered intellectually disabled if he or she has deficits in both IQ *and* adaptive behaviors. If only one or the other is present, the child is not considered intellectually disabled.

After a diagnosis of intellectual disability is made, a team of professionals will assess the child’s particular strengths and weaknesses. This helps them determine how much and what kind of support the child will need to succeed at home, in school, and in the community.

**What services are available for people with intellectual disability?**

For babies and toddlers, early intervention programs are available. A team of professionals works with parents to write an Individualized Family Service Plan, or IFSP. This document outlines the child’s specific needs and what services will help the child thrive. Early intervention may include speech therapy, occupational therapy, physical therapy, family counseling, training with special assistive devices, or nutrition services.

School-age children with intellectual disabilities (including preschoolers) are eligible for special education for free through the public school system. This is mandated by the Individuals With Disabilities Education Act (IDEA). Parents and educators work together to create an Individualized Education Program, or IEP, which outlines the child’s needs and the services the child will receive at school. The point of special education is to make adaptations, accommodations, and modifications that allow a child with an intellectual disability to succeed in the classroom.

**What can I do to help my intellectually disabled child?**

Steps to help your intellectually disabled child include:

* Learn everything you can about intellectual disabilities. The more you know, the better advocate you can be for your child.
* Encourage your child’s independence. Let your child try new things and encourage your child to do things by himself or herself. Provide guidance when it’s needed and give positive feedback when your child does something well or masters something new.
* Get your child involved in group activities. Taking an art class or participating in Scouts will help your child build social skills.
* Stay involved. By keeping in touch with your child’s teachers, you’ll be able to follow his or her progress and reinforce what your child is learning at school through practice at home.
* Get to know other parents of intellectually disabled children. They can be a great source of advice and emotional support.

**Learning difficulty**

A **learning difficulty** (also referred to as a learning disability) can be described as an issue with the brain's ability to process information. Individuals who have a learning difficulty may not learn in the same way or as quickly as their peers, and they might find certain aspects of learning, such as the development of basic skills, to be challenging.

Because learning difficulties cannot be cured, their effects may impact an individual's performance throughout life: academically, in the workplace, and in relationships and daily life. Intervention and support, which may be supplemented by counseling or other mental health care services, can help an individual with a learning difficulty to achieve success.

**WHAT ARE LEARNING DIFFICULTIES?**

Approximately 4 million children and teenagers have a learning difficulty, and many of them cope with more than one type of difficulty. Learning difficulties, which are neurological challenges, affect the way the brain receives, processes, stores, and analyzes information. Because a learning difficulty often affects an individual's ability to develop reading, writing, and math skills, a learning difficulty is typically recognized and diagnosed while an individual is in school. However, some of those affected by a learning difficulty may not have it discovered or diagnosed until they are in college or after they have joined the workforce. Others never have their condition diagnosed and may continue to experience difficulty processing information as they progress through life.

Learning difficulties indicate an individual's need for alternative learning methods. They are not indicative of intelligence level and are not the same as intellectual difficulties—learning challenges that result from sensory handicaps; developmental delays; or cultural, economic, or environmental disadvantages.

While some learning difficulties are mild, others may have a severe impact on an individual's academic performance. However, behavioral teachings tailored specifically to the type of difficulty can help an individual develop strategies to address and work with a particular challenge, and intervention can be of significant benefit. Simply having a learning difficulty does not mean an individual will be unable to succeed academically or hold an intellectually demanding position.

**POSSIBLE CAUSES OF LEARNING DIFFICULTIES**

It is not clear what causes learning difficulties, but researchers believe genetic influences, brain development, and environmental effects may all be likely to have some impact on their development.

While learning difficulties often appear in families, researchers are uncertain whether this is due to genetic causes or if this recurrence appears because children typically learn from and model their parents. Brain development before and after birth might also have an impact on the development of learning difficulties, and children who were born prematurely, had a low birth weight, or who sustained a head injury may be more likely to have a learning difficulty. Environmental effects such as toxins and poor nutrition in early childhood are also considered to be potential factors in the development of a learning difficulty.

**TYPES OF LEARNING DIFFICULTIES**

A learning difficulty might often be termed a "hidden disability." A person challenged by a learning difficulty is generally of average or above average intelligence, and many are able to hide the fact that certain aspects of academic learning give them issue for years, leaving these issues unaddressed until high school or later. The difficulty arises in the gap between the individual's potential for achievement and ability to achieve, which is often hampered by a difficulty in receiving or processing information.

Learning difficulties can be verbal or nonverbal. Verbal learning difficulties affect one's ability to read, write, or otherwise process spoken or written words, while nonverbal learning challenges can make it harder for an individual to process visual information or master abstract concepts like fractions. Some learning difficulties can also make it difficult for an individual to focus: At least 20% of those with learning difficulties have a condition that impacts the ability to focus or concentrate.

The Diagnostic and Statistical Manual classifies learning difficulties under the diagnosis of "Specific Learning Disorder," differentiating between conditions marked by impairment in reading, mathematics, or written expression. This diagnosis occurs more often in males than in females.

The Learning Disabilities Association of America lists these specific learning difficulties:

* **Dyslexia:**A condition that can affect reading fluency and comprehension, writing, spelling, speech, and recall. Dyslexia might occur along with other related conditions and is also known as a language-based learning disability.
* **Dysgraphia:**An individual with dysgraphia might find it difficult to write legibly, space words consistently, spell, compose, think and write at the same time, or plan spatially (on paper). Specifically, this condition affects handwriting and other fine motor skills.
* **Dyscalculia:**This condition may have an effect on one's ability to develop math skills, understand numbers, and learn math-based facts. It can be difficult for individuals with dyscalculia to comprehend math symbols, organize or memorize numbers, tell time, and count.
* **Auditory processing disorder (central auditory processing disorder):** Individuals with this condition may have difficulty recognizing the differences between sounds, understanding the order of sounds, recognizing where sounds have come from, or separating sounds from background noise.
* **Language processing disorder:**This condition, a type of APD, makes it difficult for individuals to give meaning to sound groups in order to form words and sentences. It relates to the processing of both expressive and receptive language.
* **Nonverbal learning difficulties:**These typically make it difficult for individuals to interpret facial expressions and body language. Visual-spatial, motor, and social skills may all be affected.
* **Visual perceptual/visual motor deficit:**Those with dysgraphia or a nonverbal learning difficulty might also have a visual perceptual/visual motor deficit, which can impact the way a person understands visual information, the ability to draw and copy, hand/eye coordination, and the ability to follow along in text or on paper.

Attention deficit hyperactivity is not considered a learning difficulty, but research shows between 30% and 50% of children have both ADHD and a specific learning difficulty. When these two conditions occur together, learning can become even more challenging.

**HOW LEARNING AND INTELLECTUAL DIFFICULTIES DIFFER**

An intellectual difficulty, listed in the DSM under intellectual disability, is characterized by significant limitations to intellectual functioning and adaptive behavior with onset before age 18. Generally, an IQ test score below 75 can be said to indicate a limitation to intellectual function. With an intellectual difficulty, adaptive behavior—conceptual, social, and practical skills—may also be limited.

An individual with a learning difficulty usually does not experience these same limitations. Those with learning difficulties may often exhibit above-average intelligence, as determined by an IQ test, and they may have developed strategies on their own to either hide or cope with a learning difficulty.

Though neither intellectual nor learning difficulties can be cured, awareness and a variety of supportive techniques can enhance and improve the condition of an individual with either difficulty.

**THERAPY AND SUPPORT FOR LEARNING DIFFICULTIES**

An individual diagnosed with a learning disability may find the diagnosis difficult to cope with, as might that person's family. When learning issues have been present for some time, the person diagnosed may find the diagnosis to be a relief, especially when the diagnosis occurs later in life. However, one might fear becoming labeled or worry that plans for the future and potential careers may be impacted.

Parents may worry that a learning disability will prevent their child from succeeding in school, but this is not necessarily the case. Teachers, mental health professionals, and specialized professionals are frequently able to work with students who have a learning difficulty or other academic concerns. These professionals can help to identify particular areas of difficulty and develop specialized learning plans and strategies, such as an IEP (individualized education program), in order to adjust learning and education strategies to best fit that student's strengths and accommodate for areas of weakness. When a child's needs cannot be adequately addressed in the original classroom, a child may be placed in a different classroom—for all or part of the school day—to receive specialized instruction, often on an individual level.

Coping with the challenges of a learning issue can be difficult. Children and teens may experience anger, frustration, anxiety, or stress as a result of the difficulty. They may become frustrated when they study extensively but receive low test scores; experience anger and stress when it is difficult to understand an assignment, or become anxious at the beginning of each new school year. These emotional issues can often compound the issue and may worsen it, but speaking about these and other emotional concerns to a counselor or therapist can be helpful. A therapist can also help individuals understand that although learning disabilities are lifelong, many methods of help and support are available. A child can also learn effective coping mechanisms to manage the difficulty and any resulting emotional issues.

Occupational therapy can be helpful to children who experience difficulty with motor skills, while educational therapists work with school-aged individuals to improve skills in reading, writing, and math. Speech therapists work with children who have language-based or reading comprehension issues and can help them improve their ability to understand and communicate in social situations. Solution-focused counseling may be appropriate for older children and teens who are aware of their difficulties, as a solution-focused therapist will be able to support youth as they address a difficulty and help them determine what might be working for them and what could be improved upon. Children and adults may also do well in therapy groups or support groups, and play therapy can help young children learn interaction skills, which may occasionally be lacking in the presence of a learning difficulty.

Counseling can also be helpful when those with a learning difficulty feel shy, anxious, or otherwise find it challenging to express themselves to others. Because emotional distress can occur as a result, talking through these anxieties in therapy may prove beneficial.

# 3 - TEACHING METHODS FOR EACH TYPE OF DISABILITY IN OUR PROJECT

## Methods and techniques used in the inclusion process of the children with disabilities – by *Gradinita cu Program Prelungit “Dumbrava Minunata” Fieni, Dambovita, Romania*

**I. A psychologist’s interview quotations about the types of our related disabilities from each partner countries.**

 Talking with our kindergarten psychologist, the first subject we approached was the integration of ADHD children in the Romanian schools. Our specialist said that “the key to a good inclusion is the early diagnosis” and that “without a diagnosis, teachers and parents don’t know how to help the special children, sometimes using wrong methods that can even aggravate the child’s condition”.

“The reject is lived and felt more intensively by the ADHD children”. So, we need really good trained teachers, so they can be able to make the healthy colleagues accept, tolerate and understand their special colleagues with ADHD. If a child is isolated, he can even try to auto-isolate himself from the world or become aggressive towards everybody around him, so the advice is that he must be treated with kindness and love in order to be helped and included in the mass school.

“Parents and teachers must become experts in treating the affection”. Even if the child is having a therapy schedule with specialists, the most part of the time is spent in kindergarten or at home. Without the good cooperation parent-teacher-specialist, the way to the progress is not easy. So the teachers and the parents must also be trained in how to help ADHD children.

Our second topic during the interview was the Autism. Here, our psychologist said that “every person that works with an autistic child, needs passion in the first place. Passion and patience. And, of course, the power to see the greatness of every small important step that the child is making through success.”

At the moment, in Romania we have around 7.000 children, mostly boys, with Autism and unfortunately this number is getting higher every year.

“In the work with an autistic child, is very important that we acknowledge that he can learn like a normal child, but in a very different rhythm. We also need an efficient reward system because this special child really needs small rewards every time he makes a progress during the day. Healthy children also need rewards, is true, but not as often as Autistic children because in his case, this reward will make him understand, in time, when he is making a good thing or has a correct attitude.”

Our specialist also said that “ the Autism never heals, the child will need support all his life but he has the chance to a normal life, depending of the gravity of the affection and if the proper therapy is started at an early age.”

“Working with autistic children is a real challenge because of their socialization problems, because of their stereotypes, and because they take every expression literally so we must choose our words carefully when talking with them (they cannot understand jokes, for example).”

The advice for every parent is to do the free screening test at their child pediatrician, at the age of 2 years in order to identify Autism as early as possible.

Regarding the Down Syndrome, we must understand that these children posses a very different psychological development. Everything about them is developing in a very, very slow way. Also, their adaptability varies from child to child. In the case of children with Down Syndrome, both parents and teachers need extra support from therapists and specialists, daily.

In all the cases, the first step in inclusion is the acceptance, the tolerance, the love for the special children, Without these, we cannot talk about success because a successful teacher is the one that teaches from the heart, no matter if the students are healthy or special.

**II. Teaching methods and lessons tools for these students**

The educational activity from our kindergarten represents in the same time an encouragement to joint action and support of every person that respects the right of every child to education, regardless of their development and learning particularities, in preventing and eliminating marginalization, exclusion and school segregation for children with disabilities, as well as the possibility of a real change in the relationship between family, kindergarten and local community.

Considering the kindergarten as the main institution where the child can learn social skills at the preschool age, the inclusion process of every child is a customization of the social adaptation, a fundamental process, of great importance for the further integration in the community life, because at this age are initially formed the main attitudes, skills and abilities.

Special educational requirements designate those special needs for education that are complementary to the general education objectives. Without adequate adaptation to these special requirements, we cannot talk about equalizing opportunities for access, school participation and social inclusion.

**1. Counseling families and children with disabilities**

All our preschool teachers are providing daily counseling for the special children in the group and weekly counseling for the parents. We also have a psychological counselor that works one day per week with special needs children.

Counselors that work with persons with disabilities and their families need to understand the experience and process of disability.

After the child is diagnosed by a specialist that is usually a neuropsychiatric doctor, our first task is to understand the **Adjustment to Disability**, in order to discover and understand the way individuals are coping and functioning while living with a disability. More specifically, it may refer to the thoughts, feelings, and behaviors of children who are trying to reach a place of acceptance and personal integration of the disability into their self-concept. Of most relevance to counselors is the understanding that adjustment to disability takes time and usually involves some sort of adaptation process which hopefully leads to better functioning and outcomes for individuals with disability.

**Factors Influencing Adjustment to Disability**

Factors known to influence adjustment to disability are many and are used by counseling professionals to better understand “the probability of successful versus unsuccessful adjustment”

Some of the factors associated with adjustment to disability discussed throughout the rehabilitation literature include depression, locus of control spirituality, self-blame or unresolved feelings for cause of disability, negative feelings and emotional distress, self-esteem, coping strategies, social support, gender, age of onset, familial support, socio-economic status and financial health, level of education and employment, and societal attitudes. Other factors include the meaning one ascribes to the disability, severity of disability, visibility versus invisibility of the disability, and the amount of stigma experienced and associated with the disability.

During the counseling process we always remember to:

- be mindful that the expressed negative experiences related to disability are real

- consider the effects that labels may have on the child

- treat special children as human beings and never as their disability

- be aware that our own attitude may affect the counseling relationship

- be aware how children with disabilities see and describe themselves

- respect the fact that the children with disabilities know their own experiences

- get the necessary training and supervision needed to effectively counsel special children

- pay attention to the abilities and strengths of the special child and incorporate them into the counseling relationship

- recognize the fact that the special child is not living “focusing” on his/her disability and limitations

- have an open mind to the shared experiences during the counseling relationship

The main way to conduct the counseling process in preschool is the communication and the therapeutic games, but we also use other specific techniques:

**Anamnesis –** conducted usually with the implication of the parents, is the method that we use in order to know, through direct discussions or investigations the significant events in life and activity of the child and the entire family, in order to understand the current state and behavior and to establish future directions for action.

In general, the anamnesis includes the social evolution events, the educational events, the family and social environment, diseases, disabilities and phenomena that generated the need for assistance.

**The Genogram –** Through this technique, the obtained information is translated into a graphical representation of the family structure, similar to the “genealogy tree”. This technique is particularly applicable in the assessment stage, having a diagnostic role.

**Ecomapa –** Like the Genogram, Ecomapa is also a graphical representation, being designed to highlight the relationship between the child and the environment in which he lives (people and institutions with whom he interacts). This technique specifies the place of a person or family in the social context. It is based on relationships, how to interact with others, intellectual performance, participation in religious, social, political, cultural activities.

Ecomapa (as well as the genogram) is based on its realization on specific symbols to represent the types of relationships. Ecomapa is done towards the end of the evaluation stage, when the counselor already has enough information to appreciate the type and quality of relationships that the child has with other people and / or institutions. Ecomapa can provide us with a clear picture of resources useful for intervention based on the quality and intensity of the child's relationships in its interaction.

**2. The Ludotherapy** is a technique by which the natural way of expressing the child (the game) is used as a therapeutic way in helping the him with emotional problems. It allows the child to act directly on the world, on a small scale, playing with chosen materials and objects, under the guidance of the adult. The child brings to light the experiences and the hidden emotions. The educator must accept whatever the child would say or do, for he needs to feel that he can manifest himself freely and openly in a warm, friendly environment.

By giving them the opportunity, children will outwit their feelings and needs in a similar way to adults. Although the dynamics of expression and the way of communication are different for children, the expressions (fear, satisfaction, mania, happiness, frustration, gratitude) are similar to those of adults. Children may experience considerable difficulties in expressing what they feel or how their experiences have affected them. If children spend time in the presence of an adult who cares and is a sensitive, emphatic person, the children will reveal their inner feelings through the toys and the materials they choose, through the things they do or games they play.

**Games for Ludotherapy Activities**

The game **"Who called Martin?"**

Aim: to develop the ability to the voices of their colleagues

Objectives: to guess who called him.

Teaching resources: a bear, a scam or a scarf.

Playing the game:

The children are placed in semicircle formation, and in front of them there is a child, blindfolded, with a bear in his arms.

At the start of the game, the teacher makes a sign to a semicircle child who shouts: "Martin!". The one playing “the bear Martin” role unfolds the scarf from his eyes, turns to the one who suspects that called him and put the bear in his arms. If he guesses, they change the roles between them.

The game **"Where did the bell ring?"**

Purpose: to develop the ability of space orientation using the hearing sense.

Objectives: To guess where the bell rang.

Teaching resources: a bell.

Playing the game:

The children are in circle formation with their hands behind. A child is in the middle of the circle with his face covered with his hands.

The teacher has a bell in his hand. Once the game starts, he moves to the back of the children and puts the bell in the hands of one, continuing to move. At one point, the teacher says: "Ready!" The child who received the bell sounds short of it, then hide it at his back and stays quiet. The one in the middle discovers his face, looks carefully at the children to surprise a move, then moves to the one he thinks has the bell, tap his shoulder and asks. He takes his hands in front and, if he has the bell, changes the roles; if he did not guess, then he goes back to the center, covers his face and the game continues the same way.

The game **"Cold, warm, hot"**

Purpose: the development of perseverance.

Objectives: to search for hidden toys, to follow the received instructions.

Teaching resources: a toy, a fairy tale.

Playing the game:

A child is tied to the eye with a scarf. Children are staying in their places while one of them hides a toy.

At the command of the teacher, the child that has his eyes covered, unfastens his scarf and starts looking for the hidden toy. When approaching the children are saying: "warm," when it is almost near: "hot", and if it goes away from the toy, the children prevent him by saying the word: "cold". The game takes place by guiding the child with these three words until he finds a toy.

The game **"The Strong Ones"**

Purpose: to develop physical strength.

Objectives: To pull the contest partner over the control line.

Teaching resources: chalk, a rope.

Playing the game:

The children are seated face to face in pairs, with their right foot on the control line. On the ground, a rope is placed next to each pair.

At the signal given by the teacher, each child grabs the rope with both hands and tries to draw his partner over the control line. Those who succeed are strong.

When organizing the game, it should be considered that the pairs are, as far as possible, about the same stature and the same amount of weight.

**3. The Mirror Technique**

In every classroom, in the Role Playing Game area, there is a mirror that children feel free to use when and as they wish.

The Mirror Technique is very important during the inclusion process of the children with special needs, because being able to see yourself in the mirror is to see yourself as you are, to meet yourself under many aspects.

The reflection has both a cognitive and an affective component.

The mirror reflection stages are: analysis, research, examination, measurement, observation and case study.

**Objectives:**

The Mirror Technique is developing:

- Concentration

- Self-discipline

- Visual communication

- Awareness of body pattern

- Positive self-esteem

When he begins to recognize himself in the mirror, to self-designate “I”, the child sketches out his own self, his own self-image, in the aspect of the total image of the body. That is a judgment with a significant value. This is the Corporeal Ego, that will stand at the foundation of the Psychic Ego and ultimately, the child will gain self-confidence in his own physical and psychological structure.

**The Mirror Technique through the game activity perspective**

The game is the main and most important activity of the childhood and in the case of special children is often the only possibility to relate and communicate.

The Mirror Technique is used when there are dysfunctional interpersonal relationships.

Examples:

**a) Emotions**

* Application area: Socialization
* Objectives:
* O1: the development of a positive state of mind
* O2: the awareness of his own body
* Tasks: Look in the mirror with a sad facial expression, then quickly change it with a happy one and say out loud: “I am happy!”. For the negative facial expression, we keep quiet. We can try other emotions like: surprised, excited, satisfied, angry, glad. Students will be fascinated by the facial expressions.
* **I am you!**
* Application area: Socialization
* Objectives:
* O1: the development of positive interpersonal relationships
* O2: the development of self-knowledge
* Here is no mirror needed, one of the students will play the role of the mirror.
* Tasks: Two students are face to face. One student takes the position of the mirror and the other student looks into the “mirror” and performs facial movements or movements of different body segments that will be imitated by the student that took the role of the mirror.

**c) Smoke the mirror!**

* Application area: Personal autonomy
* Objectives:
* O1: developing the knowledge about different temperatures (hot, cold)
* O2: developing knowledge about sensory organs: mouth
* Required materials: mirrors, napkins
* Tasks: The student will blow in the mirror blowing hot air (saying “Ha, ha, ha!”). After that, they will blow cold air (the lips are kept in the position of a kiss).

**d) Self-portrait**

* Application area: Occupational therapy
* Objectives:
* O1: developing the knowledge about the face features
* O2: developing the observation spirit and physical self-evaluation
* Required materials: water markers, head-size mirrors
* Tasks: The pupil will look in the mirror, will close the left eye (recommended) and watches around, tracing the water marker on the contour of the face as well as the lines of the face features (eye, mouth, eyebrows, hair).

Advantages of the Mirror Technique:

Using the mirror is a method of reflecting (but not imitating the movements of others) to provide a way of understanding a child's experiences. This method does not only provide important information about the child, otherwise undiscovered, but also transmits to the child the message that he is seen and accepted as he is, moves the child's attention from internal stimuli to those in the environment, which will then increase human interactions.

**4. The Knowledge of the Body and the Space-Time orientation**

**Motor Malfunction in TSA**

Besides the three large areas affected by TSA (social interaction, communication and repetitive behaviors), we also talk about difficulties in posture, coordination and motor skills.

The factors that affect motor skills in children with Autism are:

* differences in the way the brain works
* difficulties in prediction and motivation
* low muscle tone
* anxious / fearful temperament

**Exercises:**

**Posture and locomotion:**

* + Go sideways
	+ Makes a few steps back
	+ Climbs three steps, stopping and using the same foot, no support
	+ Goes on different surfaces
	+ He goes along a line
	+ He stands in one leg, with his hands on his hips and opposite leg bent
	+ Touching different body parts with his hand, at command.

**5. Geometric shapes and colors games and exercises**

 The manipulation of geometric shapes and the discovery of their attributes, as well as making constructions using flat geometric shapes, develop critical and analytical thinking, the spirit of observation, logic and cognitive behavior in general.

**6. Role playing games and dramatizations –** besides being a fun and enjoyable activity, the dramatization helps children understand feelings, know their own feelings and become more emphatic.

**7. Activities that are stimulating the natural curiosity towards the close environment**

**8. Art Therapy**

Art therapy plays an important role in the long and painful road to the recovery and social integration of children diagnosed with various forms of autism. Art therapy helps children with special needs develop, understand and relate to the world around them.

The benefits of art therapy are numerous and specialized studies are mentioning the development of imagination and creative spirit, the development of communication and relational skills, the development of expression skills and the reduction of tensions and anxiety. All this means the chance for a normal life for these genius children.

**9. Behavioral therapy – Identifying and knowing the emotion. Emotional development through specific games.**

**III. Participants final opinion and thoughts**

Every child is special, beautiful and unique and is our duty to make them all bloom and be prepared for life and for society.

Our happiness, as teachers, is translated through our student’s smiles, our satisfaction through their daily progress. Constantly, we have to be wise and choose a proper path for every child, a path that suits his needs. We all know that we cannot talk about a certain “model” or certain methods that can assure the success. It all depends on our ability to choose the most suitable methods, techniques, games and materials for every of our students, according to his needs, talents, likes and dislikes but also respecting our curricula and the age particularities in the same time. We must treat them all like equals but in the same time never forget to fulfill their individual needs and develop their unique mix of abilities.

The kindergarten is the first social environment for a child. So, including successfully a special needs child in the normal class is the first and most important step in the future inclusion in the adult society.

We consider that our Erasmus+ project “The Rainbow of Diversity” was a great opportunity to exchange good practices. We learned new methods and techniques of inclusion, we identified what is different and what is similar in our approach toward special children, we understood more about how the educational system works in the partner countries and we identified ways to improve our inclusion process.

# 4 - INTERVIEW WITH SCHOOL PSYCHOLOGIST

## 1st Special Nursery school of Patras

Special Education plays a key role in national development as it offers students an opportunity to overcome challenges in the learning environment and adopt functional skills for positive development. It often involves a multidiciplinary effort on the part of many professionals who work with these children and their families.

**1)What do School Psychologists do and what role do they play in the special education sector?**

School Psychologists help children and youth succeed academically, socially, and emotionally. They collaborate with educators, parents, and other professionals in an effort to create safe, healthy, and supportive learning environments for all students that strengthen connections between home and school. School psychologists are highly trained in both psychology and education. They are specifically trained to engage in and speak to data-based decision making, consultation and collaboration, effective instruction, child development, special education policy and ethics, prevention, intervention, mental health, learning styles, behavior, research, and program evaluation. School Psychologists are specially trained to carry out psychoeducational assessments which is an assessment of psychological and academic skills. Psychological skills include, but are not limited to: intelligence, language skills, memory, processing of visual and auditory information, planning and reasoning abilities. Academic skills assessed would include: reading, mathematics, spelling, written expression, handwriting ability, listening comprehension and oral expression skills. School Psychologists are also trained to identify/diagnose children with a range of developmental, behavioural and academic disabilities, including learning disabilities, intellectual disabilities, autism, Attention Deficit Hyperactivity Disorder (ADHD), learning problems related to motivation and other social-emotional challenges.As can be seen, their role then in special education is integral from all angles- from identification to intervention to collaboration with home and school.

**2) What are the common challenges that hinder quality service in special education sector?**

There are a number of challenges that institutions in special education face that are unique to this sector. One of the main challenges faced by schools in catering for children with special needs is resources. Often schools are not adequately equipped with educational materials and equipment to cater to students with unique needs, especially those with physical disabilities. Additionally, classroom teachers typically are not adequately trained to meet the needs of children who have learning and other challenges. Hence, this greatly limits their capacity to reach and teach each child in their classroom in a fair manner. Coursework that exposes teachers to learning and behavioural challenges is very limited in their Teachers’ Colleges. In addition to the fact that every class will have at least 1 child with special needs, class sizes are very large (in some Primary schools as large as 60 students in one class). In such a situation, teachers unfortunately are faced with the hard decision of focusing on the majority and ensuring students can do well on high stakes exams, OR, he/she can focus on the 1 to 5 students who need extra help at the potential detriment of most of the class not doing well and subsequently leading to the teacher receiving weak reviews. In every classroom the teacher has diverse learners who have diverse needs, and if teachers are not adequately prepared to meet the challenge, they will be fighting what may be termed as a “losing battle” each and every day.

Another major challenge faced by Jamaican schools in catering for students with special needs is the fact that there does not yet exist a legal policy which will stipulate classification and subsequent allocation of accommodations and services for children with special needs in the mainstream classroom. As such, schools do not have any adequate guidance in the process of identifying and subsequently providing appropriate interventions, accomodations and resources for children with special needs. A national Special Education Policy is currently still being drafted, however this is an issue that needs to be resolved without reservation and as soon as possible.

**3) What is your advice for parents/ caregivers who suspect that their child has a learning and or developmental disability?**

My advice is to seek help as soon as possible. It is better to be safe than sorry. Many persons believe that children should be allowed to grow and eventually they will “catch up”. My opinion is “What if they never do”. If the child has a real challenge, which most times is neurologically based, without formally identifying the challenges and addressing them in effective and research based ways, there is no guarantee that the child will be able to accomplish their highest potential. There are many professionals in the special education sector that parents/caregivers can turn to for support and information on how to move forward with their child, regardless of the potential disability. A parent tends to intuitively know when “something is not right”. I would urge parents to listen to their intuition and even if the child is very young (even as young as toddlerhood), get the child formally assessed. The best information parents and caregivers are able to get out of assessments is identifying strengths and weaknesses that will help to direct intervention planning for that child.

**4) What are some of the misconceptions concerning children receiving special education services?**

There is unfortunately still the misconception that children who have special needs will “pass on” their disability to other typically developing children. I have been privileged to be affiliated with and employed to an inclusive Early Childhood institution for the past 7 years, and I am yet to see where typically developing students have been worse off or adapted negative behaviours and traits because of being educated alongside children with special needs.

I think many persons believe that the disability IS the person, instead of A PART of who the child is. This is the whole reason behind “person first language”. That is, one should say, “a child with autism” instead of “an autistic child”, because the autism is only part and parcel of who the child is. I would love to see us move even further along in this country in understanding that children with special needs can accomplish many things, as long as we do not place “handicaps” in their way and hinder them from realizing their highest potential. In line with this viewpoint, assessments and interventions are still seen as “unimportant” to many, especially for children who have learning disabilities, ADHD and other behavioral or social emotional diagnoses. However, if a child has diabetes or some other medical condition, do we not do all we need to in order to treat the problem. So it should be as well with these lower incidence diagnoses, but diagnoses that will have a lasting impact on their life and ability to function in the wider society.

**5) Once a child has been referred to a School Psychologist, what can parents expect?**

First of all, the referral has no significance if the parent does not actually follow through with the referral. However, once an appointment is made, the parent can expect to meet for a detailed interview with the School Psychologist to discuss background information of their child. The child is then observed in their school setting (if necessary) and a formal psychoeducational assessment is conducted. From this assessment, the School Psychologist is able to determine what abilities related to learning may be resulting in any noted challenges or delays. An important part of this assessment process is also feedback from teachers and other critical persons involved in the child’s life. After this detailed assessment of the child’s abilities and academic skills is done a formal meeting is held with the parents/caregivers where the results and interpretation are discussed at length. Additionally, relevant recommendations are made as it relates to next steps for the child and how to potentially remediate any challenges noted, as well as hone in on strengths identified. When possible and given permission by parents, the School Psychologist may also make contact with other stakeholders such as the school or other professionals (e.g. Speech therapist, behaviour therapist etc.) to ensure that the child will have the necessary provisions to address their needs

## Italo-Swiss Education Center School of Rimini – Italy - Specialized psychologist for work with students with severe disabilities.

How many years have you been working at Ceis?

I have been working at Ceis for 9 years.

What's your role?

I am an Educational psychologist; I make informal psycho educational evaluations, I offer support to teachers to help them face difficulties that may be found when implementing and adapting [curricula](https://en.wikipedia.org/wiki/Curricula) to diversities shown by students and to face problem behaviours, showing them how to teach these students.

Do you work independently or in collaboration with other professional figures?

I never work alone, I work with teachers and we make decisions together.

At what time of year do you make the first observation about the child?

I make the first observation between September (start of the school year) and October; in October we make the Individualized Educational Program (IEP), so that we can write in IEP the observations and the objectives that we found during the first meeting.

How important is the collaboration of the family in the realization of the educational project? How many meetings are there per year?

The collaboration of the family is very important, because the project should be done together with them; however just a few families are interested in designing the project: al lot of them just try to do at home what we do at school and some of them are just not interested in sharing the project. However, we always ask them what is important for them and, if we can, we try to reach that objective.

I meet families just twice a year, but teachers meet them more often.

How important do you think school inclusion of children with disabilities is and how much do you think it is for "typical developing" children?

I think inclusion, for children with disabilities, is important because they can learn appropriate behaviours from them and / or their support; a problem about inclusion is that times and spaces are not always suitable for them, but I observed that in an inclusive environment they learn to fit in the “normal” environments ad so they can behave appropriately in other normal environments like parties, restaurants…

I also think that inclusion is important for typical developing children because they learn that differences are not scary and that everyone has needs (even the typical developing children can have needs, every child has his own); they also learn how to support children with very special needs, so often they become very sensitive and attentive even with themselves.

Did you ever set goals for a child and change them radically during the work?

A lot of times! Sometimes we set objectives but when we try to work on them we realise that they are too difficult or useless so we change them. I think this is not really a problem if we are aware that we need to resolve the problem in a different way.

Which operational tools are used for the drafting of the educational project?

We use tests like VB-MAPP or checklists like ESDM Curriculum Checklist. I also use a checklists based on the Curriculum of Francesca Degli Espinosa.

What do you like best and least about your job?

My favourite thing is seeing the children learn to communicate and becoming autonomous; I like it when they start to interact with their school mates and when they are happy to work with their teachers. I also like it when parents say that they can go on holiday or wherever they want without worries.

I don’t like when we have severe problem behaviours and I can’t solve them entirely.

What organizational differences are there between the "winter" educational intervention and the one implemented in the summer camp**?**

There are a lot of differences: in winter the children follow the class routine, sometimes working with their class mates, sometimes working alone and sometimes working with other children with disabilities. They work a lot on academic skills apart from other skills; teachers train typical developing children to interact with children with disabilities and viceversa.

In summer we have less children and we have no classes: there are only 2 groups (one with children from age 3 to age 5 and one from age 6 years upwards) in which we have a lot of children with disabilities. A few years ago, we decided to create a space designed for children with severe disabilities to provide them more clarity and peace; they sometimes play with typical developing children and sometimes they work and play alone or with other children with disabilities. They work less on academic skills and more on play and domestic skills.

# 5 - SOCIALIZATION OF THESE INCLUSIVE STUDENTS

## Inclusive contexts and organizations

by Italian Partners

In my previous speech, speaking of the experience of "widespread support" at the Italo-Swiss Educational Center - CEIS - in Rimini, I said that a school, an educational service that places children with greater difficulties at their center of attention (disability, behavior , etc.) are a school, a better educational service for all.

This statement finds its reasons in the finding that children with more difficulties force teachers, educators and the educational institution that really want to welcome them to continually seek ways, times, the most effective operational and technical tools to help them overcome and / or manage the difficulties and to be able to develop their potential to the maximum.

This continuous research shapes, supports and reinforces a culture and a pedagogical practice oriented to the individualization and the personalization of the educational and formative intervention on condition that they are realized in the context of a group and an educational community.

A culture and a practice that all children have the right to be able to fully express their individuality. Knowing how to grasp and enhance the differences of each of the children is the indispensable condition for implementing a welcoming and, above all, effective educational environment, capable of grasping and bringing out the motivations and interests of each, energy and the engine of learning and new acquisitions.

This way of understanding educational work in services is the condition for being able to speak concretely of an "inclusive educational environment", in the sense that all the differences have the necessary space to express themselves and be valued as a patrimony of a group within which everyone feels to be able to express their identity and that, through it, is part of the group itself.

An inclusive environment is such because everyone receives the answers to their individual needs in a context in which he enjoys the rights and possibilities of everyone, where everyone is caught in his ecological integrity, an environment that helps concretely coexist even with "difficult" differences that often they are only because we are not used to it. The sooner we have the opportunity in life to live with these differences, the less likely we are to develop unjustified "mistrust and fear".

In order to be such, an inclusive educational environment needs to be supported and placed within an institution and an organizational structure coherent with an inclusive approach, in which the sharing of choices, responsibilities, all oriented to the realization of a common project, prevail .

Institutions, including educational institutions, tend to "specialize" to meet the needs of effectiveness at the lowest cost, with the consequence of delimiting their field of action and their specificity.

Another aspect that seems to connote educational institutions more and more frequently, is the prevalence of formal and bureaucratic aspects over educational ones. The school of our country is a worrying example.

The educational institutions constantly run the risk of making a bureaucratic dimension prevail for its own sake which, as such, is structured for a rigid division of responsibilities with a single concrete objective: the discharge of individual responsibilities. A quality educational path, on the contrary, promotes the assumption of personal responsibilities.

Finally, a further connotation of the institutions seems to refer to a managerial governance approach from above, of a purely economic nature, to respond to the presumed needs of the institution's efficiency. A simplistic way that almost always produces damage and that is adopted when one is not able or willing to activate an action of sharing and co-responsibility towards the educational project of all the actors, in particular the teachers / educators.

If these processes are not governed, and unfortunately often are not, from an inclusive pedagogical will and culture, they contribute to reducing and often canceling the possibilities and conditions for a dynamic of relations and mediation between individuals, children and adults, indispensable for an educational and training course capable of pursuing the objective of enhancing diversity as a condition for quality cultural and personal growth.

An educational and training pathway capable of pursuing these objectives requires teachers and educators who are able to meet and listen to the children they are dealing with, to be flexible, to be able to continuously reflect on their work, on children and their responses to stimuli , knowing how to reformulate and redirect their educational and training action by welcoming and involving children in the conquest of new skills and competences. To be able to operate in this way, they must be placed within an organizational structure that, even within clear rules, roles and functions, provides them with the necessary competent support and the space to operate with the necessary freedom inside of shared projects.

The whole organization, administrative, managerial, work organization, of an educational service that wants to enhance diversity and, therefore, be inclusive, requires that all components consciously respond to this need.

The administrative apparatus should ensure its specific competence to interpret the rules (in our country many and often unclear and contradictory), in a formally correct way but constantly seeking the most functional modalities for the realization of the educational project.

The management component of the service should work to ensure the support of teachers / educators to work in order to operate in the most effective way for the realization of the project and to check that the work of the teachers follows the methods and the agreed modalities.

The organization of work, first and foremost for teachers, must be such as to correspond to the needs of the educational project. For example, working hours, while respecting work contracts, must be articulated in such a way as to respond in a functional way to the needs of the project, including those that require sufficient time for continuous comparison, collegial reflection, programming reformulation , continuous training, even if this sometimes requires their articulation different from the "customs" and from alleged and / or misunderstandings "acquired rights". For example, I consider very serious the choice, made in the past years by many employment contracts under the pressure of teachers and trade unions, to restrict the amount of time to devote to the activities of programming, reflection, to those for the care of relations with parents, training, etc.

# 6 - ORIENTATION OF THESE STUDENTS TO THE CLASS AND TO THE SCHOOL

***Patras***

## Principles of implementing inclusive education

**Change in system**

Analysis: where is change needed?

Before planning and implementing an inclusive education programme, it is important to gain an overview of the whole education system – to identify where change is needed. Change in one area could be made ineffective by the absence of change in another area.

Gather baseline information

Relate any existing policy on the educational inclusion of disabled girls and boys to the situation and practices ‘on the ground’. But, beware of spending too much time and money gathering data. Using international estimates is often a sufficient starting point, which can then be complemented with well-targeted, local information gathering.

Inclusive policy-making

Planners need to realise that an inclusive education system benefits disabled girls and boys.

Accepting responsibility

In traditional systems, it is seen as being the fault of the disabled children and the families if children do not come to school, or do not learn. By contrast, in an inclusive system it is recognised that schools have an important part to play in disabled children not attending, and not learning. School systems need to accept responsibility for children’s learning, by making their systems and methodologies more relevant and responsive to disabled children’s needs.

Accessible learning environment

The accessibility of the learning environment is crucial for all children to participate equally, and be fully included. Families, and the children themselves, need to be closely involved in discussing accessibility issues. These could include: mobility and transport issues, the physical accessibility of buildings, attitudes, teaching methods, the language of instruction, the relationships between teachers and children.

Curriculum flexibility

The curriculum and exam system need to be relevant to all children. Where there is a flexible curriculum, all children have a chance to learn and benefit from education, and their achievements can be recognised.

**Schools**

Adopt a whole-school approach

Schools need to be encouraged to become self-sufficient in responding to children who are disabled. In the ‘whole-school’ approach, all staff members (all teachers, assistants, caretakers, etc) are involved in promoting inclusive practices. Too often in schools, this is the responsibility of only one or two particular members of staff. All members of staff within the school need training and awareness-raising about the inclusion of disabled children, and good leadership is needed from education managers.

Additional support

If additional support exists within the education system, it is advisable that this is based at district or provincial level, not in individual schools. This is to ensure that schools accept their whole-school responsibility for all the children in their care, and do not rely on advisers. Additional resource persons can provide support from the district, or national, level.

**Managing schools**

Good management is essential when educational changes are introduced. Local education managers, and headteachers, can ensure that schools are well supported, and can help develop networks between schools. To promote more inclusive practices in schools, education managers can:

Ensure that teachers are not overloaded

Careful planning by managers ensures that teachers have manageable workloads. This includes issues such as class size, and number of children identified as having impairments or difficulties in learning.

Reward good teachers

Reward systems for teachers who show extra skills can be put in place by managers. This can be done through existing promotion or grading systems, not through a parallel ‘special’ system.

Allocate time for teachers to observe each other

One of the most effective ways of improving teachers’ practice, and encouraging them to be more flexible and creative, is to enable them to observe each other. Managers need to prioritise this in their planning, and ensure that teachers have opportunities to reflect upon their experience. This is a valuable form of in-service training. They also need to provide ongoing support for teachers who are beginning to work in new ways.

Identify out-of-school children

Managers need to ensure that all local disabled girls and boys are tracked, admitted to school, and helped to continue in school if difficulties occur.

Promote multi-sectoral collaboration

 Co-operation with other relevant sectors is an essential part of the management of inclusive education (eg, health or social services). It is possible that disabled children and their families may be receiving services from a variety of sources.

**Teachers**

Teacher-training

Teachers need training about inclusive principles and the basics of disability, to ensure that their attitudes and approaches do not prevent disabled children from gaining equal access to the curriculum. Training should be ongoing, provided in short courses (or modules) and should take place within a local school environment, preferably their own school. Training should take place at both preservice, and in-service, stages. Problem-based, on-the-job training is more effective than theoretical pre-service training. In fact, encouraging teachers to meet on a regular basis to discuss their problems, and develop confidence in their own abilities, is arguably the most effective form of staff development.

Teachers’ responsibilities

Teachers need to understand, and accept, that it is their responsibility to teach all children, since all children have a right to education. Motivating teachers to take on this responsibility can be the key to success. Once they are motivated, they will need regular practical support and constructive feedback. Reward systems can be useful to sustain the commitment of teachers who show additional skills, but this should be through existing systems of promotion and grading. Being recognised as a creative teacher, and seeing disabled children achieve results will, in itself, be rewarding for a teacher. Awarding additional payments for teaching disabled pupils tends to be divisive.

Teaching methodology

Teachers with experience only of rote teaching and learning methods are likely to find it difficult to adapt their style to one that promotes more active, disabled child-centred methods. Changes in teaching methods could include rearranging the classroom, so that children can work in small groups; encouraging a ‘buddy’ system where older, or more academically able, children are assigned to work with those experiencing difficulties; introducing locally available materials for play activities, or teaching maths and new vocabulary. Teachers need opportunities to try out new methods, share ideas, and observe other teachers using different methods.

Access to information

Teachers need access to easy-to-read information about international documentation, and how to implement more inclusive practices. Reading about the experience of other teachers working in a similar context helps teachers to reflect upon their own experience and gain confidence to try out new ideas.

**Children’s participation**

Child-to-child methodology

Children are a valuable and often under-used resource in education. They are, usually, far more accepting of disability than their teachers and parents. The child-to-child approach is an extremely effective way of mobilising children’s participation. Children have been actively involved in challenging negative attitudes in their communities towards disability, identifying children who are excluded from school, carrying or pushing physically disabled children to school, writing notes for deaf children in class, tutoring disabled children in their homes.

Disabled children’s groups

It can be very helpful in some contexts to encourage disabled children to meet in groups in order to develop a positive self-identity, to be exposed to disabled role-models, and to share experience about the particular difficulties they may be facing. E.g. in the case of deaf children, they need to have the opportunity to develop their sign language skills. Disabled adults and disabled people’s organisations can be very helpful in supporting the development of such groups.

Involvement of parents

Parents of disabled children are often the strongest advocates for the rights of disabled children to access education. They deserve support to achieve their objectives. However, many parents are unaware that their disabled children have a right to attend their neighbourhood schools. Indeed, the interests or objectives of parents may not always correspond with the needs and interests of their children. Parents may need help to organise themselves as a group, and to challenge exclusionary practices in education. Where possible, parents of disabled children should be supported to work in partnership with disabled people’s organisations, and other community-based groups, in advocating for these rights.

Participation

The involvement of disabled children, young people and adults in the formulation of policy and practice is crucial. Involving small groups of disabled children and young people, and supporting them to speak out about their priorities and needs, is a first step towards making education child-centred and more useful for their daily lives. Their involvement can often speed up the development of more inclusive practices. Their knowledge, and expertise in disability, should be respected at all levels.

# 7 - TEACHING THE RULES TO PROMOTE BEHAVIOR CHANGE IN INCLUSIVE STUDENTS

## The diffused support

**Integration projects for children**

***Analysis of an Italian case***

Children BES means children with special educational needs. In this wording there is a hope, a possibility of openness and relationship with respect to other children, those "without special educational needs" (even if we ask ourselves the question of whether the world actually exists). The adjective "special" seems to emphasize, in a particular way, the positive aspect, the possibilities inherent in these needs, emphasizes them not as a burden, but as a possibility that can really materialize only through the implementation of good that is: a series of well-coordinated educational actions, which require the questioning of well-established educational structures.

In this article we will try to recount some experiences in which this attempt is underway. The adult protagonists of these experiences (masters, educators, educationalists) have had the opportunity to meet and exchange ideas, opinions, advice. This article arises from these exchanges as a further contribution to give strength to a pedagogy of special needs.

**What does it mean to welcome diversity?**

More or less all of us, speakers of this article, we start from experiences that have deep analogies. The shared basic coordinates are defined by the «Widespread support» project of CEIS. The CEIS is a pedagogical experience born after the war by the Swiss Relief. The creator and guide of the experience was Margherita Zoebeli. The «Sostegno-diffuso» project was born from the collaboration of Andrea Carrevaro with the CEIS pedagogists and provides an essential basis for working with BES children, a general sharing of care and a deep involvement of the family in the educational path designed for children and for the classes in their entirety. We quote from the text of the project:

The educational and training work aimed at integrating pupils with disabilities saw the presence in the classes of titular teachers and support teachers [...] but with the passing of time this operating structure has brought out some problematic aspects that can be summarized in:

- a great difficulty in integrating the work of these different figures which tended to assume the contours of the separateness of the roles and the consequent fragmentation of the interventions on the students;

- the difficulty in containing the thrusts to the delegation: to the teachers in charge of the class the work with the class group, to the support teachers the support;

- an increasingly strong request from parents of disabled students to increase the hours of intervention of support teachers considered as the only indicators of the quality of school work.

It seems clear to us that the indispensable framework for all development and learning activities is the establishment of a "good and meaningful relationship" between the educator and the student, but if we think about it, it seems even clearer that this good and meaningful relationship , in reality, it must concern all the people who are part of the mechanism put into operation at school.

This in full awareness that welcoming means taking charge of the problems that those who are welcomed bear and that these problems must become objects of common interest. In this we define one of the central functions of the teachers, who are bearers of concrete ways of coming to grips with the issues that are gradually presented in the classroom, with respect to relationships and not only to rules and learning.

The arrival of a child in difficulty cannot be a question that concerns only the teacher but also the children of the group. We have to imagine an organic path, where the separation from the group of children with individualized programming occurs only when necessary, but for the rest of the time, most of them, there is a profound interpenetration with the didactic and growth paths of both teachers and of the other children.

**Stories to understand a little better**

The teacher Pina Leporanico from the "Dalla parte dei bambini" school in Naples tells us.

There is a teacher who cannot work with Gino because she hums while she tries to get the students to do their homework. This teacher usually unloads the child to another teacher who usually has more grip on him. This even if the teacher in question is working in another class. Acting in this way the first teacher becomes an obstacle in the relationship between Gino and the rest of the children, indicating exclusion as a practice of resolving difficulties (the problem is invited to sit in another room).

Another teacher, on the other hand, reacts to Gino's disturbing exits, often transforming them into a moment of welcome towards him. Gino's companions in those moments express their best. They have developed a very deep affection for him, and tend to accompany him in most of the day: in reading a text, in making a painting, in playing in the garden, but at the same time, wisely, they are not too forgiving compared to to some of his exuberances.

To favor an inclusion process, it is very helpful to structure the work by foreseeing possible waste and slowdowns due to the presence of a child "with problems". Children and adults must feel ¬ as a natural part of class life the fact that different needs and speeds must be met and that the overall mechanism must be calibrated on the weakest. The moral essence of this principle must be aware of both children and adults, who must organize themselves and behave accordingly.

**Integration of teacher actions**

Let's start with two objectives clearly expressed in the text of the CEIS project.

An individualized, calibrated, and detailed daily work plan in relation to the needs and potential of each. A concrete, continuous and meaningful coexistence in the classroom and with the companions considered as a context and indispensable support for the quality of the learning of all the students (disabled and non-disabled) [...] For these objectives to be realistically achievable it is necessary to put in place a organization of teachers that allows everyone to have each of the students present, their abilities and their difficulties, their different styles of study and their interests. We considered that this would have been possible, especially for disabled students, only if each of the teachers could contribute concretely and operationally to the realization of the individualized and specialized educational project. In parallel: only if the support teachers could participate directly and concretely in the realization of the training interventions with the class group. In general terms, the practice of "widespread support" allows to overcome the serious problems deriving from the delegation to the teacher of support of responsibilities and activities with disabled children.

Directly inspired by the CEIS project is the Integration Project of the "Dalla parte dei bambini" school in Naples conceived by Pina Leporanico. It constitutes a first step towards the realization of "widespread support". Once every two weeks, class support teachers offer a themed workshop for the class. During the time devoted to the laboratory the titular teachers dedicate themselves to support. The programming of the laboratory is the fruit of collaboration between all the teachers. Immediately we realized that the main difficulty consists in winning a series of cultural resistances that prevent teachers, owners and support, even from imagining different roles from those already codified (finishing the program, taking care of their child) . Slowly, trying to overcome inveterate habits, the project moves in the direction of co-planning of the routes, in which everyone shares the burden and responsibility of both the group guide and the individual paths of children in difficulty. This is because, says the teacher Amoroso, "an educational path, so that it is really effective, must be shared by all the teachers who work with the class group, [...] which means that the roles of all teachers are interchangeable, so that everyone is recognized as a group teacher. Integration is not a one-way path: it is not only the child who must be integrated into the group but also the community that must be integrated with the student ».

**Stories of non-acceptance**

There is a child in an elementary class who manages to stay in the classroom only a few minutes. The support teacher, after making arrangements with the other children, manages to convince him to work in the classroom. This child cannot control the voice and the maths teacher, who at that moment is lecturing, to minimize the annoyance, calls the other children in a circle next to him. Everyone calls unless the child is annoying.

An autistic child gives out classes. The comrades try to calm him down. It's a scene quite dense with tension, some companions manage to calm it down. The children would obviously like to do something for him, but the Italian teacher says: «All right, enough! Now we have to do Italian and get on with the program, "inviting the support teacher very clearly to sit outside with the child who, in her opinion, has already solved her problem.

One thing that no teacher should ever say about a BES child and his needs: "There are other children too!" Or, reacting to his excesses: "Other children get distracted!" Phrases like these, spoken in a hasty way, to break off in the bud a difficulty born in the classroom, constitute a false moral justification in the face of the teacher's inability to solve the problem by hiding it. An excuse to which teachers should never resort to avoid dealing with a child in difficulty in the first place is the need to carry out the program and therefore not have time to work with the support staff. "Too much fire! », Another terrible slang phrase from teachers. To add the fact that "we need to go ahead with the program" is one of the most widely used ways of avoiding our responsibilities. So there is the support teacher.

**The laboratories**

Let's start with the story of the teacher Alessandra Amoroso.

Our listening and dramatization workshops take place weekly; Danilo (the disabled child) knows that at the time of the circle he must take his chair and place it in a space of the classroom duly dedicated to this activity. He sets up the chair for me and the class teacher as well, and he gradually calls his companions to form the circle. Remember the rules of the circle with children, I start reading the story, while the colleague participates like the other children. Sometimes we dramatize some roles at the request of the students themselves. Following the listening activity, I always ask the children to tell the story, to Danilo we ask to recognize the characters thanks to the use of images and to choose which character to act. For Danilo this represents an opportunity to increase his attention span and to take appropriate behavior for listening to others, to improve communication and also to enhance his bodily expressiveness. For everyone it is an opportunity to express themselves in different ways: there are those who prefer to choose the costumes among the available school material showing their creative abilities, who proposes to dramatize the role they prefer by showing their interpretative abilities, who decides to play the role of the narrator showing his abilities of reworking and oral expression; but it is also an opportunity to engage in challenging activities such as telling the story while having difficulty speaking in public or having little ownership of language.

Alessandra Amoroso works in a suburban school in Palermo, the principal of this school is Fabio Passiglia, who for seven years has been a support teacher and whose commitment to disabled children is known throughout the city.

The idea that permeates this ongoing attempt in the various realities we are talking about is that the difficulty in accepting a BES child is mirrored in the difficulty teachers have of receiving support teachers. The achievement of this goal, the knowledge and mutual appreciation among the teachers, which inevitably end up influencing the quality of the classroom climate, involves a deep crisis and a radical abandonment of a series of customs, according to which the concept Reception is only a formal and rarely substantial issue. We know well that substantiality requires hard work, but the achievement of a real responsibility for all the problems the children carry is a moral duty for those who teach from whom one cannot derogate.

The organizational form of the laboratory can be helpful, since it sometimes favors the questioning of roles. We come out of the arduous and rigidly codified field of materials and we are forced to invent and experiment with something else. We start from scratch, and it becomes easier to get to know each other, to recognize their own limits, but also some unexpected advantages. The Italian teacher Giovanna Passananti of the school "From the side of children" writes: "*Changing the vision of a child's world to get him out of isolation is a utopia that sometimes leads you to seek hidden, unthinkable ways, but urges you also to retrace with other senses the same old ways. A color lab experience was the source of change. The experience of the other and with the other initiated the process of inclusion in the class of a child with her wheelchair and her language of looks and abrupt movements. I still remember the anxieties and worries of adults, perhaps too concentrated on spaces, tools and timetables, to lose sight of the lightness of a gesture that even a child, forced to search in his daily arduous and tiring communication codes, can grant himself with the tip of a dripping brush. In the spontaneous silence that was born after the preparation of the colors, when every child was there in front of his own paper, Gioia's laughter was now a routine; just like the spoonfuls of glue and colored powder in the transparent glasses, the discoveries, casual or those fruit of careful experimentation, the splashes of color that took on bizarre paths, the stories that accompanied the colors and the desire to narrate them to others. We have learned to divide a space that is sometimes reduced, choosing to give more to those who needed it, we have lived the expectations with pleasure, we have discussed in depth and with passion our works, we have tried to live this experience together without the oppressive weight of judgement*".

This is a clear message that requires a rethinking of our schooling. It is necessary to revisit teaching programs from the perspective of interculture, stimulating the participation of all in the construction of knowledge and favoring forms of cooperation.

The didactic laboratories represent a valid working method to create a culture of participation, as they stimulate the students to look for autonomous paths, in constant confrontation with others, learning to share ideas, projects and tools to carry them out. Furthermore, their implementation forces teachers to work together for success. Alessandra Re writes, one of the support teachers of the school "From the side of children": "*The arrival of a child in difficulty is an issue concerning the whole class group. All children and all teachers are called to participate and to share because only in this way can something authentic be created to create true human relationships. A lesson studded with relationship problems arising from the presence of difficult children emphasizes a moral problem which gives rise to a need: to welcome the other* ”.

The suggestions proposed so far make us see well that in a possible organization of school work according to the senses so far outlined we can find various positive aspects, and those that seem to us to be of greater importance are well described by Giovanni Sapucci, rapporteur, together with Andrea Canevaro , of the CEIS project on «Widespread support»: Sharing of individual projects by all teachers with a reassuring effect on parents about sharing their children's needs and, above all, a shared awareness of what each individualized intervention requires , avoiding useless waste of time and "empty expectations" in working with disabled students.

Drastic reduction in requests for hours of support, as parents have positive references from all teachers on the implementation of the project that the group is carrying out with their children and [on the fact] that, even in the case of the occasional absence of the teacher of reference, the work plan proceeds anyway. Expansion of the richness of interventions and stimuli for all pupils in the class with a particularly positive effect on motivation and the consequent involvement of all pupils in school work.

Greater effectiveness and continuity in the implementation of specialized practices with students in a situation of gravity and beyond.

We close with the words of Alessandra Re: "*The difficulty that disturbs a class can create relationship and social capital. Accepting a different skill in the classroom means stimulating the entire group of children to a sharing that can become an opportunity for growth for everyone. And then, yes, all those children who find themselves receiving one or more difficulties in their classes will roll up their sleeves to do together. Thus children will begin to cooperate on equal terms, to reason, to try to understand, to try to get to know each other in depth in order to value each other's resources* ".

# 8 - OPINIONS OF THE PARTICIPANTS

## Thoughts and opinions on Special and Inclusive Education - *Melpomeni Kordistou Headteacher of 1st Special Nursery school of Patras, Greece*

I teach children with various types of Learning Difficulties since 22 years. And I can honestly say that in teaching children of varying levels of ability, I have discovered a few things about myself also as a special pedagogue.

First of all, I have come to realize that my initial understandings about special and inclusive education and what it entails were wrong in that they were off-course as to the desired intent of inclusionary teaching.

When I first started teaching children who needed adaptations and modifications to the regular program, I thought, "This is going to be a lot of work." I even might have thought that I needed to make things fair -- balancing the time I invested in the students who were struggling with the time allotted for assisting the needs of those students who required more specialized educating. My initial understanding might have leaned more towards the belief that inclusive education is okay as long as it is equal. As long as everyone gets an equal slice of the pie.

Teaching in this way is exhausting. You are forever running from student to student trying to balance out your time, making sure that everyone has their two minutes of 'face time' and that all have equal opportunity.

But I have since come to believe that this kind of teaching makes as much sense as parenting in this way might play out. It's not a great way to do it

On the other hand, when you see the positive outcomes and benefits that inclusionary practice makes in the life of a child, there is no turning back to do it any other way. The kids I teach are worth the time and effort it takes to include them, and they deserve an equitable, fair education regardless of what they bring to the classroom table. This is our mandate as teachers: to provide the necessities and advantages for kids so they can learn in their BEST way.

To do otherwise is an injustice.

Mostly, what I have learned about inclusionary classrooms is that being with people that are different in so many wonderful ways has made me a better, more compassionate person. And I have sensed that same impact being felt by both able-bodied students and dis-abled students in like manner. Differences often enhance relationships. And when one embraces the difference and uses it as an opportunity to grow and develop their character, that person is a better person for it.

Having been part of many inclusionary environments over my lifetime, I have come to realize that being with people that challenge my thinking, provoke intelligent discussions, fine-tune my character and stimulate my passions- these are the people who help me become a more empathic person. And since this has been a life-goal of mine to journey towards greater empathy and understanding, I would venture to also say that being with those who are different than me has allowed me to become a better person.

And so has it allowed my students to become the same. Better people. Brighter lights. The hope for a more compassionate future.

And that this is so is also evident in the ways that the students who have been part of inclusive classrooms treat one another, both able-bodied and those with disabilities alike: by and large, they treat each other with mutual respect and honour, both showing great compassion and understanding, one for the other. And time and time again, it is the students who have been part of inclusionary classrooms who exhibit the greatest understanding for difference and the most compassion and empathy for those who are not the same as them.

That's the extraordinary power of the inclusive classroom.

## Meeting between different experiences and scholastic and social integration of students with special needs - *By Giovanni Sapucci, director of the Italo-Swiss educational center of Rimini - Italy*

The Rainbow of Diversity project confirms us in the conviction that the exchange of experiences between directors, teachers and educators from different countries constitutes an extraordinary moment of training and reflection on educational issues. In particular those concerning the integration of pupils with special needs.

Italy is the only country that does not have special schools for these children, which are integrated into ordinary classes with the support of specialized teachers and educators. This school organization started in the late 1970s, more than 40 years ago.

As it was called an almost unique situation that originated from the particular school organization of our country, where special schools were very scarce.

A very complex school organization, the Italian one, which has been refined over the years. Today it has reached a rather high level of effectiveness and efficiency, even if for various organizational reasons it is very difficult to always ensure teachers and educators prepare to face the specific difficulties of the students.

The most evident result of a school organization such as the Italian one has shown that the habit of living together in the same school environment allows children with difficulties to build a network of significant relationships much wider with their peers and with the "ordinary" school environment "Which in this way becomes an additional support, improving the level of motivation to the commitment and overcoming the surmountable difficulties. On the other hand, it helps all children and teachers to know how to relate and get to know children with more difficulties, being able to discover their abilities and potential. In other words, to overcome the many prejudices that constitute one of the greatest factors of scholastic and social marginalization.

A complex organization that often has to face a difficulty that often leads to investing only in the socialization component of children with disabilities, leaving the specific educational and rehabilitative interventions scientifically calibrated to the needs of each child in the background.

Specific professional skills present in special schools in the countries where this type of school is present and which Italian colleagues were better able to learn about during the various moments of exchange and training activated in The Rainbow of Diversty project.

An important knowledge because it is precisely on this side that the Italian school will have to strengthen itself in the coming years.

1. Useful links: http://hubmiur.pubblica.istruzione.it/web/istruzione/disabilita [↑](#footnote-ref-1)
2. http://archivio.pubblica.istruzione.it/dgstudente/disabilita/ntd/azione4\_5.shtml#cts [↑](#footnote-ref-2)
3. Normative References: Law 5 February 1992, no. 104, art. 12 comma 9. [↑](#footnote-ref-3)
4. see the MIUR Guidelines on http://hubmiur.pubblica.istruzione.it/web/istruzione/dsa [↑](#footnote-ref-4)
5. (Todorova, E., Diagnostics in language deficit in dyslexia, 2005) [↑](#footnote-ref-5)