CHAPTER 5

Working with Families of Children with Disabilities

WHY THIS TOPIC MATTERS

Over 10% of the school population in the United States has been diagnosed with disabilities. These children are eligible for special education services. The majority of children with disabilities will be placed in regular education classrooms. As a teacher, you will be expected to understand the terminology and issues related to special education. Learning how to work with families of children with disabilities will enable you to teach their children more effectively.

LEARNING OUTCOMES

After reading this chapter, you will be able to do the following:

- Describe the importance of the Individuals with Disabilities Education Improvement Act (IDEIA) for families.
- Describe the history of special education laws and how IDEIA's six principles governing the education of students with disabilities provide support for families and their children.
- Discuss the impact that a child with disabilities can have on a family.
- Describe why early identification of disabilities is desirable, and how early intervention helps families ensure their children achieve their maximum potential.
- Define individualized education plan (IEP), least restrictive environment (LRE), and inclusion, and describe how to build effective strategies to build relationships with families of children with disabilities in the school setting.
- Assess the importance of community agencies in meeting the needs of persons with disabilities and the needs of their families.

The number of children identified as having one or more disabilities has increased dramatically over the past 30 years as federal laws mandating appropriate intervention and education have been passed. In 2013–2014, 6.5 million, or 13%, of children ages 3–21 were identified as having a disability (NCES, 2016).

This is in addition to the more than 357,000 children from birth to age 3 who have also been identified (ECTA, 2016). **Inclusion** has become the norm in schools, and ensures that children with disabilities are included with their typical peers as much as possible. The extent to which a child is included with his/her typical peers should be determined by the strengths and needs of the child. Some children are included with their peers in general education full time, while others are included for certain parts of the day such as art and snack. Although rare, some children receive their education in separate classes or schools.

Pria and Nerrav were three months away from the birth of their second child, a girl, when Pria's water broke. Unable to stop her labor, the doctors delivered the baby at only 26 weeks' gestation. The baby, named Prisha, was not breathing when she was born. After several minutes, medical personnel got Prisha breathing, and quickly rushed her to the Neonatal Intensive Care Unit (NICU). When the doctor came to see Pria and Nerrav later that day, she told them that Prisha was stable but had a long road ahead. After months in the NICU, Prisha was discharged, and Pria and Nerrav finally took their new baby home. As Prisha grew, it became evident that she had sustained brain damage from the lack of oxygen at birth. She was slow to speak, walk, and learn, but she was also happy, energetic, and kind.

Like many parents who have a child with severe disabilities, Pria and Nerrav were unprepared for the birth of a child with special needs. As Prisha grew older, they clung to the hope that she would begin to catch up with her peers, but she continued to develop at a slower rate. Some years later, as they played on the beach with their older son, Rohan, and Prisha, now age 7, they couldn't imagine life without their spirited little girl. True, she had had some difficult medical problems early on and now needed accommodations in school, but she had a sunny disposition and brought them all much joy. They didn't think of her as an abnormal child, but as a child who in many ways was similar to her typically developing brother.

Some parents learn about their child's disability at birth or soon afterward like Pria and Nerrav; others find out later. For example, a pediatrician might raise concerns when a child fails to meet developmental milestones for motor or language development, and may recommend further screening. Other children are not identified as having a disability until they enter preschool, elementary school, or even middle or high school, when their learning differences become apparent.

The **Individuals with Disabilities Education Improvement Act (IDEIA)** was originally titled the Individuals with Disabilities Education Act (IDEA) and you will see the two acronyms used interchangeably in this and other texts. This legislation ensures that Prisha and other children with disabilities receive support and services. Prisha and her family received **early intervention services** when she was an infant and a toddler. IDEIA provided the necessary special education supports to allow Prisha to attend a community nursery school when she turned 3. She now attends second grade in a public school, where she receives special education, speech and language services, physical therapy, and counseling.

CHILDREN WITH SPECIAL NEEDS AND THE INDIVIDUALS WITH DISABILITIES EDUCATION IMPROVEMENT ACT (IDEIA)

Children with disabilities are a subgroup of the larger category of children with special needs. The special-needs group includes gifted and talented children, children who are linguistically or culturally different from the mainstream, children who are at risk for school failure because of poverty or other social conditions, and children with health and medical conditions that may impede their success in school. These groups may need special intervention to achieve their maximum potential in school, but they are not protected by the IDEIA.

Some children receive accommodations through **Section 504 of the Vocational Rehabilitation Act of 1973**. This law is designed to protect children who do not have a disability as established by IDEIA, but are at risk because of health problems, physical disabilities, attention problems, or other conditions that may interfere with school success. Students with attention deficit hyperactivity disorder (ADHD), for example, do not qualify for special education services but may require **accommodations** to function well in general education classes. The responsibility for developing the **504 plan** lies with the principal and teachers rather than with special educators.

Many school systems attempt to identify children with special needs to differentiate the curriculum for them. English-language learners may receive instruction from teachers who are trained to work with this group. Title I services may be offered in schools with a high percentage of children at risk because of poverty. Children who are gifted and talented may be grouped together when possible, and the pace of instruction may be accelerated and content enriched with opportunities for creative and critical thinking. These interventions, however, are not mandated by IDEIA.

EXAMINE YOUR BELIEFS AND PRACTICES

The first time you work with a child with a disability, you may feel uncomfortable. This is normal. Address your uncertainty by asking questions and educating yourself on the disability. Use resources like the Council for Exceptional Children and the Federation for Children with Special Needs as a source of information about specific disabilities. You will be better able to support parents who are raising children with special needs when you have increased your knowledge and comfort level. Determine that you will model and teach the importance of treating all people with respect, regardless of their abilities.

Children with Disabilities

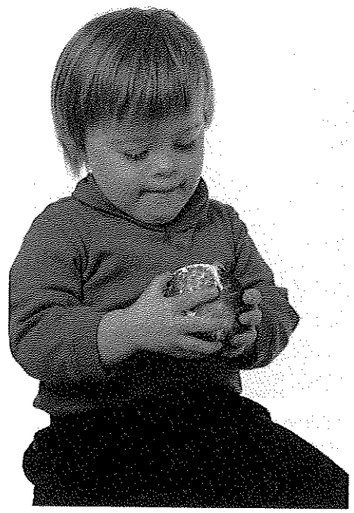
Although it is impossible to calculate exactly how many children with disabilities are in the United States, the US Department of Education's annual report to Congress on the education of children with disabilities provides the most accurate estimate (see Table 5-1). As of fall 2015, 6,814,110 individuals ages 3 to 21 were receiving special education services under IDEIA.

The majority of school-age children have mild disabilities, of which slightly more than two-thirds fall into two categories: specific learning disabilities and speech or language impairments. The rates of autism spectrum disorder (ASD), however, have been steadily increasing in the past ten years. Whether this is due to changes in diagnosis and a broadening of the criteria used to identify children with autism is unclear at this point. The Autism and Developmental Disabilities Monitoring Network, a group of programs funded by the Centers for Disease Control and Prevention, is collecting data to try to determine the prevalence of autism in different parts of the United States in an effort to understand why approximately 1 in 68, or 1 to 1.2 million, children have been identified with ASD (CDC, 2016).

Person First Language

The kind of labeling shown in Table 5-1 will alert you to the types of disabilities included under IDEIA. The percentages of children within each category are listed, but it is important to remember that these numbers refer to individual children. Each child should be considered as an individual and not as a member of a category. When thinking about children with disabilities, be aware of the person first and avoid labeling that highlights the disability as an individual's most important characteristic. Using **Person First Language (PFL)** reframes the terminology to describe the person with a disability; the disability does not define the person. For example, saying "A boy with autism" is correct; saying "the autistic boy" is not. Even better, calling children by their names and referring to their disabilities only when necessary is the most respectful approach. Parents will appreciate your sensitivity in using language that recognizes their children as individuals who are more than their disabilities.

Now that you have a sense of the range of children with disabilities, we will provide an overview of the federal legislation concerning individuals with disabilities. Then we will look at the issues associated with serving the needs of children with disabilities within the family, school, and community. Collaboration within these social settings is essential to achieve the most successful outcome for these children.



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Children with disabilities are a subgroup of the larger category of children with special needs.

TABLE 5-1 Number of Students Ages 3 Through 21 Served Under IDEIA, Fall 2015

Disability	Number (Ages 6–21)	Number (Ages 3–5)
Specific learning disabilities	2,348,891	8,252
Speech or language impairments	1,044,286	330,881
Intellectual disabilities	418,540	13,767
Emotional disturbance	346,488	2,755
Multiple disabilities	125,232	7,755
Hearing impairments	67,426	8,893
Orthopedic impairments	41,232	5,756
Other health impairments	907,207	23,808
Visual impairments	29,944	2,799
Autism	550,405	72,350
Deaf-blindness	1,280	163
Traumatic brain injury	25,488	1,118
Developmental delay	149,306	285,388
All Disabilities	**6,814,410**	**763,685**

Source: US Department of Education (2017). *IDEIA data.* Retrieved March 29, 2017, from *https://www2.ed.gov/programs/osepideia/618-data/static-tables/index.html.*

Check Your Understanding 5.1

Click here to gauge your understanding of the concepts in this section.

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Children with physical disabilities can receive a therapist's services in a variety of settings, including their home.

OVERVIEW OF FEDERAL SPECIAL EDUCATION LAWS

In 1975, Public Law 94-142, the Education for All Handicapped Children Act, ushered in a new era for recognizing and ensuring educational opportunities for children with disabilities. In the subsequent years, America has undergone considerable adjustment (not without difficulty) in providing appropriate educational programs for those with disabilities, such as restructuring buildings to allow access, reorganizing staff, and modifying curricula. Perhaps most of all, more educators have a new outlook on, appreciation for, and interest in accommodating children with special needs in regular classrooms. In many ways, these mandates will blend with your efforts to establish a multicultural emphasis for your future classroom.

Many adults today can remember a time when children with disabilities did not attend school. Many were cared for at home; some were institutionalized. Most of these children were marginalized, and lived their lives outside the mainstream of society. In some parts of the world, this remains the fate of people with disabilities. Federal laws enacted over the past 30 years in the United States protect children from exclusion from school based on their disabilities. These laws also provide early intervention services for infants, toddlers, and preschoolers within their families and other appropriate settings that will help them achieve their potential.

Several legislative endeavors since 1975 have expanded and clarified the provisions for special education. In 1986, legislation expanded school programs to cover preschoolers (ages 3 to 5) with disabilities. The notion driving this move was that early identification of disabilities meant that additional time and instruction would enhance the child's later schooling. It was only a matter of time until the first 3 years of a child's life were also considered for special services when needed. Therefore, in 1997, legislation brought services to infants and toddlers. Specialists meet with parents of children in this group to help establish a better foundation for their later schooling.

Now known as the Individuals with Disabilities Education Improvement Act (IDEIA), this legislation has been immensely important in making certain that children, adolescents, and young adults up to age 21 have access to and benefit from special education services. The law is very specific about who is eligible for special education and how this education is individualized to meet the person's unique needs. Consequently, special education is defined as a service and not as a place. Instruction may take place at home, in a hospital, or in a general education classroom, and includes speech therapy, physical therapy, occupational therapy, and other services necessary for the child to benefit from education.

Several provisions in the legislation are designed to protect the rights of children with disabilities. The following six principles undergirding special education reform have become the specialized language of special education.

1. ***Free Appropriate Public Education (FAPE)*** Mandates that all children, regardless of the presence of a disability, are entitled to a free education appropriate for their needs in a public school.

2. ***Nondiscriminatory and multidisciplinary evaluations*** Requires a nondiscriminatory evaluation to determine if the student has a disability and, if so, the kinds of services the student should receive. This rule requires schools to assess children in their own language using a team of evaluators who avoid procedures that may be culturally or racially discriminatory.
3. ***Individualized Education Program (IEP)*** States which services (general education, special education, speech therapy, etc.) the child will be receiving. The IEP is the heart of each child's special education program.
4. ***Least Restrictive Environment*** Requires schools to merge children with disabilities with typically developing peers in regular education classrooms to the maximum extent appropriate for the child.
5. ***Procedural safeguards*** Establishes the safeguards that make the school and parents accountable to each other for carrying out the student's IDEIA rights, protecting all students' right to privacy, and establishing procedures for legal redress if violations occur.
6. ***Parent and student participation*** Requires schools to collaborate with parents and adolescent students to design and carry out their special education programs.

Parents and special education leaders have been at the forefront of the movement to establish laws that guarantee children with disabilities an equal opportunity for education. It was because of the commitment and **advocacy** of these families and educators that legal actions in the courts and in Congress have evolved to include children with disabilities in education. In some cases, parents continue to struggle for appropriate educational services for their children in the courts. Ideally, families, schools, and communities work together, sharing their expertise, support, and resources to provide the best outcome for all children.

IDEAS FOR YOUR CLASSROOM

Build and Maintain Relationships with Parents

The majority of children with disabilities are educated in public school settings side by side with their typically developing peers. Although you will work closely with all parents, it is particularly important to establish a close relationship with the parents of children with disabilities. The following suggestions will help you begin building a partnership with these parents:

- *Make sure parents know you are excited to have their child in your classroom. Make the parents feel welcome in your classroom as well, and respect their expert knowledge of their children and their needs.*
- *Use e-mail, telephone calls, and/or notes to introduce yourself to families.*
- *Contact families early in the year with positive comments about their child. Many parents of children with disabilities may have received mainly negative information from other teachers.*
- *Determine the best way for you and the parents to communicate with each other, then do so regularly.*
- *Contact families to share good news. E-mails and text messages are fast and efficient ways to do this if parents use this technology.*
- *Listen carefully to parents' concerns and perceptions even if they are different from yours.*
- *Realize that unless you are raising a child with a disability, you really cannot know what it is like for these families, so show your willingness to learn from the parents. Although digital, phone, and written messages save time, try to connect face to face with parents when possible. Personal connections are best to show interest and concern.*

Check Your Understanding 5.2
Click here to gauge your understanding of the concepts in this section.

FAMILIES RAISING CHILDREN WITH DISABILITIES

Adhera walked into Cedar Lane Nursery School dreading the conversation she was about to have with Ms. Johnson, her 3-year-old daughter Chanda's teacher. As soon as Adhera sat down, Ms. Johnson smiled kindly but wasted no time getting to the point of the conference. "She constantly disrupts circle time, she grabs things from other children, she hits, kicks, and bites her teachers and friends on a daily basis," Ms. Johnson said. "I'm afraid we are not going to be able to continue having Chanda here at Cedar Park. We don't feel we can keep the other children safe from her aggressive behaviors. We don't think this is the right place for her." Blinded by her tears, Adhera rushed from the room and out to her car.

Emotional Impact

Having a child with special needs presents unique challenges to parents, and the initial discovery can be an intense and traumatic event. Many parents of children with disabilities go through an adjustment process similar to grieving. Initially, parents may experience shock, denial, and disbelief. These feelings may be followed by periods of anger, guilt, depression, shame, rejection, or overprotection of their child.

Although research indicates that some parents move through a grief cycle of confronting, adjusting, and adapting, it is inappropriate to believe that all families will react in similar ways. Families are unique, and should be supported sensitively in their adjustment process and approaches to raising a child with a disability. Depending on the nature of the disability, parents may need to make many changes as they learn how to provide the appropriate care and accommodations for the child. Often, the family's routines, resources, and activities will need to be modified, and this can cause resentment and stress.

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Families raising children with disabilities need community service personnel who are sensitive and helpful.

The Sibling Support Project is an organization dedicated to lifelong concerns of brothers and sisters of people with disabilities. Siblings have unique needs that are often left unaddressed. Parents may have higher expectations for typically developing siblings in terms of achievement and responsibility, but may not be able to give them adequate time and attention. Family stress due to financial difficulties associated with caring for a sibling with a disability affects all members of the household. On the other hand, family members may also develop strong bonds with each other as they work together to meet the needs of the child in need. The impact on the family will differ depending on the condition and its severity as well on as the emotional and financial capabilities of the family. In all cases, however, families raising children with disabilities need teachers and community service personnel who are sensitive, tolerant, and helpful.

Multicultural Issues

A growing concern among educators and child advocates is the disproportionate number of minority children who receive special education services. African American and Hispanic students are more likely to be referred to special education than are European Americans. Although multiple factors may account for the overrepresentation of children of color in special education (Ford & Russo, 2016), one possible explanation is the fact that children from minority backgrounds are also disproportionally from families with low incomes. There are strong connections between low income and exposure to toxins, poor nutrition, lower birth weight, and less stimulating home and child-care environments. However, the referral process for special education is subjective, and bias could be a factor in diagnosing more minority children as having disabilities than their percentage of the population seems to justify. Greater efforts are needed to prevent mislabeling children of color as having disabilities.

When working with families from minority ethnic or language groups, it is essential that professionals display respect for the parents' culture and provide the legally mandated translations of important documents and a translator during meetings about the child. Some families will have great difficulty acknowledging that the child has a disability. They may disagree with the diagnosis or not wish that their child participate in suggested services. These disagreements can occur with any family, but professionals working with families from diverse cultures must be especially sensitive to misunderstandings and miscommunications. The collaborative nature of developing an individualized plan for children with disabilities requires a high level of trust between professionals and parents, and this may need time to develop.

As an educator or community service professional, you will be part of the stronger efforts that are being made to provide early intervention for children at risk for educational failure because of poverty or lack of English language in the home. There is longstanding evidence that early intervention and quality early childhood experiences can significantly reduce children's need for special education services later. To reach those children most in need of these services, professionals need to work hard at communicating well with families who may be struggling with the possibility that their children have disabilities and who may distrust the educational system.

Medication

The decision to use drug therapy to help children with Attention Deficit Hyperactivity Disorder (ADHD), autism, and other emotional disabilities is a separate medical decision made by parents in consultation with a physician. Teachers should never recommend that a parent medicate their child; that decision should be made by the parents and the child's doctor. Stimulant drugs have been helpful in controlling the symptoms of ADHD and helping children perform better in school. But deciding to give medication to a child can be difficult for parents. Not only are there known short-term side effects—such as loss of appetite, stomach pains, headaches, irritability, sleep problems, and mood changes—the long-term impact of these drugs has not been well researched. Children diagnosed with anxiety or mood disorders such as depression or bipolar disorder may

also benefit from medication therapy, but there is even less research on the impact of these drugs on children in the long term.

Parents are understandably cautious about having their children take medication, and they worry about their children's growth, their health, and the long-term effects of drug therapy. Children who are medicated should have full-treatment plans that include behavior interventions and therapy as needed. When medication is given, parents and educators need to monitor the child closely to ensure the right dosage is given. Finally, teachers must respect and support the decision of parents who oppose medication for their children and disallow its use.

Respite and Support

Parenting a child with a disability can be demanding, and the more severe the child's disability, the more challenges the family faces. Programs, training, and support groups for families raising children with disabilities can sustain parents and provide much-needed information. These supports can also help families find others who are dealing with similar issues. Research indicates that families who participate in support groups are more likely to be involved in their children's schooling (Newman, 2004), and this involvement leads to higher achievement.

Respite care, which provides temporary relief from the caretaking responsibilities associated with parenting, is especially needed for families whose children have problem behaviors and severe disabilities. Respite care is available for parents and siblings of children with special needs. If you feel that a parent needs "a break," speak with the specialists (early interventionist, social worker, physical therapist, etc.) who work with the child; they will often be able to locate resources in your area. Parenting children with significant needs can be very stressful, and if the parents do not have a network of extended family and friends to assist them, they can become burned out from trying to meet the demands of their responsibilities. Parent to Parent programs can be especially helpful as a source of support, as these groups are made up of families in similar situations.

IDEAS FOR YOUR CLASSROOM

Ways to Support Parents

As the teacher of a child with disabilities included in a regular education class, you will play an important role in the child's family. Once you have established a relationship with the parents and learned some of the family's aspirations for their child, you can help them connect with other families in the classroom community. Isolation can be a big problem for families with children with disabilities, and you will be in a good position to help the child form relationships with other children that can extend outside school. You will also want to partner with other professionals such as social workers, school counselors, and psychologists to help families locate support groups, therapy, print and online resources such as Parent to Parent USA, and sources for respite care. Don't assume that you know what families are going through, however; use your good communication skills and rapport to uncover their needs.

Check Your Understanding 5.3

Click here to gauge your understanding of the concepts in this section.

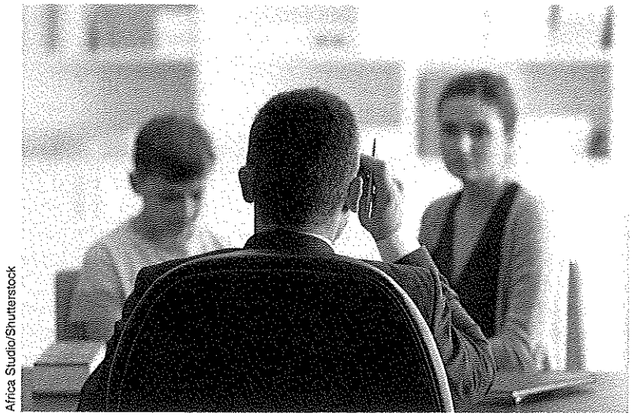
EARLY IDENTIFICATION AND INTERVENTION

When Chanda was dismissed from Cedar Lane Nursery School (see the vignette in the previous section), her mother was devastated. For several years, Adhera had been ignoring the warning signs that Chanda was developing differently than others. She walked and talked very late, and seemed to have difficulty getting along with others. Now that the nursery school had confirmed her fear that something was wrong, Adhera finally decided to have some testing done. Through the **child find** process in her local school district, Adhera was able to have her daughter evaluated. When Chanda was identified as having a language processing disability, she became eligible to attend a prekindergarten program in a local elementary school that served children with developmental delays and other developmental needs. By the time Chanda was in first grade, she was progressing well in a general education class with support from the resource teacher of special education. Chanda's success in school was largely the result of the **early identification** of her disability and the intervention services she received.

Video Example 5.1

This video offers insight into parent and teacher perspectives on the value of early identification and intervention. What are some of the benefits of early intervention?

The benefits of early identification and intervention are well documented (Kelly, 2012). When children's learning problems are recognized early, behavior problems and school failure can be prevented or reduced. Early intervention may include special instruction, speech and language work, physical therapy, occupational therapy, and/or other services. Because early intervention is a family-centered approach, the parents of children with disabilities also benefit, as they learn ways to support their child's development at home. Society profits from the early identification of children with disabilities as well, because these children, like Chanda, are often ready to participate in a general education classroom at significantly less cost than that of extensive special education services.



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A family and school team is a key feature in working out an IFSP for a child with special needs.

Early Intervention Program for Infants and Toddlers with Disabilities

The Early Intervention Program for Infants and Toddlers with Disabilities was established in 1997 as Part C of the IDEIA—1997. To be eligible for services, children must be experiencing a developmental delay in cognitive, physical, communication, social or emotional, and/or adaptive development, as measured by appropriate diagnostic instruments. Children whose diagnosed medical condition has a high probability of causing developmental delay are also eligible for services. In 2016, approximately 357,715 children ages 3 and younger were receiving early intervention services. This represents almost 3% of the population of that age group (sourced form ectacenter.org/partc/partc-data.asp).

The evaluation of infants and toddlers requires a comprehensive multidisciplinary approach, which often results in a variety of needed services, such as family training and counseling, home visits, speech or language pathology and audiology therapy, occupational and physical therapy, and health services. By law, these intervention services need to be provided in the child's home, in a child-care facility, or in another setting that is natural for children in this age group. The law also requires that a service coordinator be provided to help guide the family and manage the efforts of the various agencies that provide services to the infant or toddler.

Children with more significant disabilities often begin to receive services as infants. These services are guided by the **individualized family service plan (IFSP)**, which is required for children from birth to age 3. Developed once a child has been deemed eligible for service, this plan is based on the results of comprehensive assessments, and is reviewed at least every six months. Parent participation in the development of the IFSP is essential, and parent input is sought for decisions related to evaluation, identification, possible placements, and services. Although a detailed discussion of the IFSP is beyond the scope of this text, you may want to search online for the "ECTA Center." From the home page of the website, search for the following in the search box located on the website: "State Examples of IFSP Forms and Guidance." This will provide examples of IFSP forms used by various states. Figure 5-1 provides an overview of the categories addressed in this important document.

FIGURE 5-1 Components of the IFSP

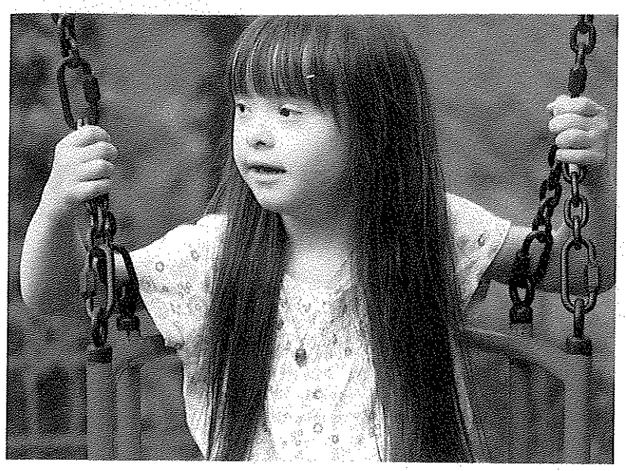
Section I:	**Enrollment Information** (name, contact information for parents and caregivers)
Section II-A:	**Family Considerations for the IFSP** (parents' perception of the child's and family's strengths and needs, including a checklist of concerns)
Section II-B:	**All About Our Family** (narrative of family members, what they do, neighborhood information, and other people important to the family)
Section II-C:	**All About My Child** (checklist of things the child likes to do or things parents would like the child to do, as well as a narrative section on people who spend time with the child)
Section III:	**Summary of Child's Present Levels of Performance** (completed by the IFSP team as a summary of their observations and evaluations of the child's physical, communication, and social and emotional development, cognition, and motor and adaptive skills)
Section IV:	**Natural Settings/Environment** (includes a checklist of settings that could be considered as options, as well as those that have been selected and why they reflect the most natural settings for the child)
Section V:	**Major Outcomes** (a list of the major goals, current status, changes needed, and what will be done to accomplish these changes)
Section VI:	**Transition Planning Checklist** (information about the transition to community programs)
Section VII:	**Early Intervention Services** (a summary of the kinds, duration, and outcomes of the related services the child has received, including service coordination and assistive technology)
Section VIII:	**Other Services** (medical and other services that the child needs but are not funded by the infant–toddler program and the funding source)
Section IX:	**IFSP Implementation and Distribution Authorization**
Section X:	**IFSP Team** (names, titles and roles, agencies, and signatures of all people involved in the interdisciplinary team)
Section XI:	Progress Summary/Modifications/Revisions to Outcomes in the IFSP

✓ **Check Your Understanding 5.4**

Click here to gauge your understanding of the concepts in this section.

CHILDREN WITH DISABILITIES IN SCHOOL

Although parent involvement and input remain essential as the child enters preschool, families who have been part of the infant–toddler program experience a transition at this juncture. Children who are diagnosed with disabilities as infants and toddlers transition to the preschool program when they turn 3, which means they shift from the IFSP to an **individualized education program (IEP)**. This can be a significant passage for the child, as services at the preschool level generally are provided outside the home. For some parents, this can be a traumatic adjustment, because they may be separated from their child for the first time. Other children are newly diagnosed as preschoolers, and still others may not be identified as having a disability until later in elementary school. In the following section, you will find out about the services provided by the preschool program of IDEIA and the legal aspects that apply to children during the elementary school years.



Denis Kuvaev/Shutterstock

IEPs should reflect each child's strengths and interests in order to support their needs.

Preschool Program

One aspect of IDEIA mandates school districts to locate, identify, and evaluate preschool children with disabilities within their communities through the child-find process. The goal of child find is to locate children who may need early intervention. As you work with parents of young children, you can help them determine if their child may need such screening. Working with the family to answer the following questions might be helpful:

- Is the child developing typically and achieving developmental milestones?
- Does the child exhibit appropriate behaviors for his or her age level?
- Are there any factors in the child's developmental history that cause concern?
- Are there any situations in the home that might influence the cognitive, physical, linguistic, and emotional development of the child?
- Does the child require more stimulation and nurturance than the typical child?

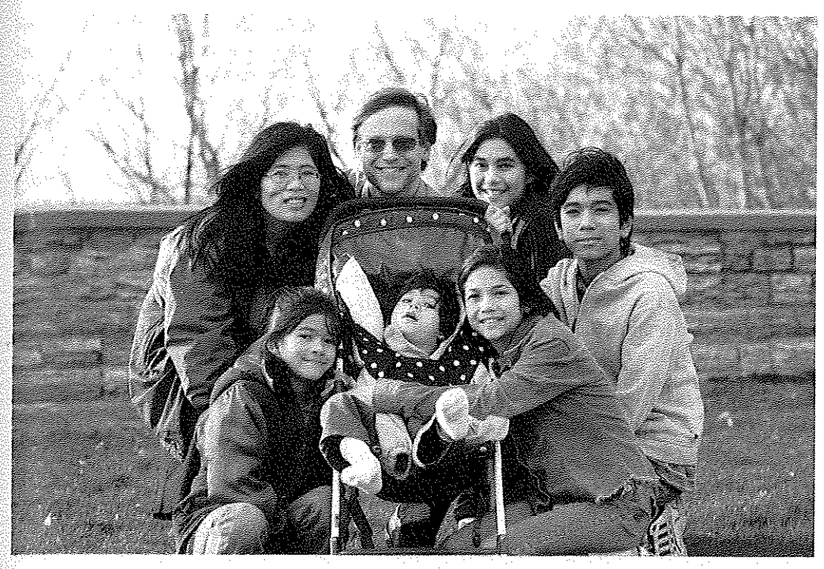
Child-find efforts are enhanced by the work of pediatricians, early childhood educators from Head Start, child care and nursery schools, personnel from community agencies such as public health and social services agencies, and others who interact with preschool children. These professionals can alert parents to the child-find process, and can refer the child for testing if the parent is reluctant.

After an initial screening, the child-find team will arrange for a full evaluation of the child's strengths and weaknesses for children who require it. If the child is diagnosed with a disability, the next step is to develop an IEP for intervention, which will focus on instruction goals for the child.

Another section of IDEIA devoted to preschool mandates that 3- to 5-year-old children with a diagnosed disability receive a **free appropriate public education (FAPE)** and the related services that they require. Children who receive services under the early intervention program for infants and toddlers with disabilities often make a smooth transition to the preschool program, because they develop the **adaptive behaviors** needed for social acceptance in a general education setting. Many parents decide to enroll their children in neighborhood nursery schools to ensure they have the same opportunities as their peers.

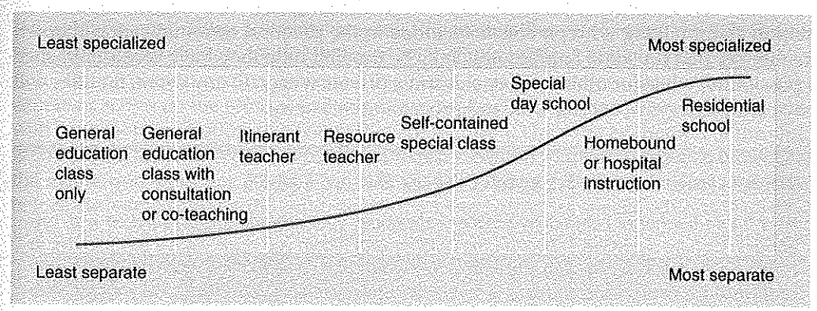
Most nursery schools and child-care centers have worked with children with disabilities for many years. Typically, teachers and staff are responsive to working with families and the related professionals on meeting IEP goals. Early childhood special educators, speech pathologists, occupational therapists, and other service providers come to nursery schools and child-care centers as needed to work with children with IEPs. They often include a small group of peers when appropriate. Service providers also collaborate with the teachers and staff, and are part of the educational team. You may want to read the article by McCormick, Wong, and Yagi (2003) for a full description of how one nursery school planned for the successful inclusion of a child with Down syndrome.

Attending school with typically functioning children allows children with disabilities to be in the **least restrictive environment (LRE)** based on their educational needs. (This is another facet of the law, which requires children with disabilities to be in the most normalized settings possible.) Chanda, the child with a language disability who had been excluded from Grove Nursery School, was later placed in the preschool classroom at a nearby public elementary school. In this program for children with developmental delays and diagnosed disabilities, typically developing peers are invited to participate in the program, allowing all children to benefit from the experience of learning together.



Jaren Jai Wicklund/Shutterstock

Early intervention services support both children and families.



Pearson

The Special Education Continuum of Services

General Educators and Children with Disabilities

Children with disabilities receive a continuum of services provided by both general and special educators, as well as other specialists. Hence, there are a number of ways that general educators have responsibilities related to children with disabilities. Children with a diagnosed disability may be placed in a general education classroom full time in what is often termed **full inclusion**. These children will also receive services from a special educator and other specialists. Some children may receive their academics in a resource special education room but be included in general education for certain subjects such as art and music as well as other social times such as recess. Children whose needs

indicate a more restrictive placement may be placed in a self-contained special education classroom in their elementary school, a separate special education public school, or a private special education setting. Based on their needs, some children may be educated in a home or hospital setting. The individual child's IEP will determine the extent of his or her participation in a general education classroom based on the child's needs and the LRE.

It is beyond the scope of this text to provide detailed information about each kind of exceptionality and the ways that teachers can work with students with particular disabilities. Teachers need to look at each child as an individual and differentiate instruction based on the strengths and needs of each child. Besides **differentiation of instruction**, general educators will need guidance on how best to provide the **accommodations and modifications** specified in a child's IEP. It is essential that general education teachers and other professionals who work with children with disabilities recognize the importance of working as a team with parents, special education teachers, and other specialists. The most successful outcomes result from the collaborative efforts of a team working together for the child's optimum education.

THE REFERRAL PROCESS As mentioned earlier in this chapter, some disabilities are diagnosed at birth, others during the preschool years, and still others during elementary school or later. General educators may be the first to suspect that a child has special learning needs. Their observations will assist the team in diagnosing a disability. General educators do not have the responsibility or training to diagnose disabilities, but they are often in a position to recognize learning and behavior difficulties that suggest a child may need evaluation. Talking with the family about the need for further assessment—to determine if a disability is present—can be a challenging task for a teacher. More information about talking with parents is included in the practical communication chapter. Remember that for some families, this may be the first time they have considered such a possibility, while for others it may confirm a private worry. In any event, families will have unique ways of coping with and processing this news.

EXAMINE YOUR BELIEFS AND PRACTICES

As a future teacher or community service professional, your attitude toward children with disabilities will have a powerful effect on the children with whom you work. Take a few minutes to reflect on the following children and write a few words that come to mind when describing each of them: a girl who is blind and deaf, a blind man, and a teenager with ADHD. Put your list aside for a moment and do a similar activity using adjectives to describe the following people: Helen Keller, Stevie Wonder, and Cher. If your descriptive words differ from list to list, you may want to think about some of your attitudes toward disabilities. Begin to educate yourself about the person-first approach mentioned in this chapter, and about why individuals with disabilities prefer not to be termed handicapped or have their disability described as their primary characteristic. The term "mental retardation" is no longer used. Please make sure you do not use this term and instead use the term "intellectual disability." Search online for the organization "R-word" to see the work that is being done through social media to end the use of the word "retarded." Remember: Words matter!

THE ASSESSMENT PROCESS The assessment process begins at the pre-referral stage. During this stage, the team will meet and review all existing data and determine if additional information is needed. This includes information from the general educator and parents, both of whom are part of the team. After additional data are collected, the team determines that further evaluation is needed. If it is, the team will begin the assessment process, which is called the referral. The evaluation team is made up of certain core members, including a special educator, speech and language specialist, and school psychologist. As needed, occupational and physical therapists will also be included. They will

gather information from the child's parents and from former and current teachers who have worked with the child, and determine the types of testing that need to be done. They may also call on the school psychologist, speech and language specialist, or special educator to evaluate the child using various assessment instruments. Parents, teachers, and other concerned individuals are core members of the team. While they do not administer any assessments, they should be present when the results of the evaluation for a specific child are discussed. See Figure 5-2 for a summary of the referral and placement process.

Ideally, parents will take the opportunity to become active partners in the evaluation and placement process, and attend all meetings concerning their child. As the experts on their child, parents have much to contribute to the evaluation team, but they may find it intimidating to sit at a table with professionals who use terminology and abbreviations that may be unfamiliar to a layperson. It is essential that the core members of the team work hard to make the parents feel welcome and ensure that they understand everything said about their child. If the parents do not speak English, a translator must be made available, and important written materials must be translated into the native language.

After the child has been evaluated, the evaluation team will meet to share the findings of the various professionals who have tested the child. Each professional will supply a written report that summarizes the results of his or her testing together with the observations and insights of the child's parents and teachers. At this point, the team will determine if the child has one or more of the impairments that are considered disabilities, and will decide if the child is eligible for special education services.

Once eligibility has been established, the team writes the IEP and determines what specific services the child needs. Parents will receive copies of the IEP; they will also receive reports on their child's progress in meeting IEP goals several times during the school year. If the child is not making adequate progress, the team will meet to revise the IEP. Parents may also request changes to the IEP based on their perceptions of their child's growth.

The protections of due process of the IDEIA legislation determine the timing of the course of action on the referral and admission to special education service programs, as well as the written notices to parents that are required. Once the evaluation of the child is completed and it has been determined that the child is eligible for special education, the evaluation team has 30 days to write the IEP. Parents must be notified in writing before the team evaluates the child, before the school provides special education services to the child, and before the school changes the IEP. Parents must give permission for the child to be evaluated and to receive special education services. Schools are also required to inform parents of their child's educational rights and to let them know how they can request a hearing if they disagree with the school's findings with regard to their child.

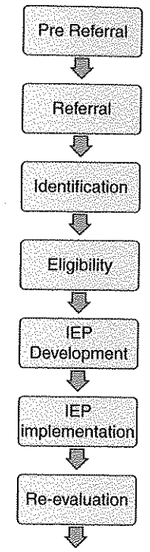


FIGURE 5-2 Processing a Referral for Special Education. School personnel follow a sequence of events and meetings after receiving a referral. The sequence may be repeated annually or modified.

- ***The IEP.*** The **individualized education program (IEP)** is, in a sense, a contract setting out the goals and instruction for a student with a disability from ages 3 to 21. The term "individualized education program" has been in education practice for the past 30 years, and it means basically what it implies—a plan worked out by the team of general education teachers, specialists, parents, and sometimes the learner to serve the learner's needs. (See Figure 5-3 for the general components of the IEP.) At least once a year, an IEP will be written for the child. Every three years, children who have an IEP will be reevaluated to ascertain if they still require special education services.
- ***Assistive Technology.*** **Assistive technology (AT)** devices are accommodations provided for individuals with disabilities to perform tasks that otherwise might be difficult or impossible. Such devices can include items, pieces of equipment, or product systems, whether acquired commercially off the shelf, modified, or customized, that are used to increase, maintain, or improve the functional capabilities of individuals with disabilities. The term *technology* may conjure up images of computers and other hardware, but it actually refers to high-, mid-, and low-tech devices that help children with disabilities accomplish practical tasks.

FIGURE 5-3 Components of the IEP

Part I:	**Identifying Information** (child's name, birth date, grade, current placement)
Part II:	**Meeting Information** (type of meeting, participants, and notice and permission information)
Part III:	**Current Assessment Information** (data source, scores, strengths, indicated areas of need)
Part IV:	**Eligibility** (educational impact of the disability, disability codes)
Part V:	**Parent Information**
Part VI:	**Progress on IEP Goals and Objectives on Benchmarks**
Part VII:	**Instructional Areas** (annual goals and short-term objectives for each instructional area)
Part VIII:	**Supplementary Aids and Services** (needed accommodations, modifications, and adaptations)
Part IX:	**Nonparticipation with Nondisabled Peers** (percentage of time the student will not participate with nondisabled peers in the general education environment)
Part X:	**Primary Special Education Services**
Part XI:	**Related Services to Support Instruction** (speech/language, occupational or physical therapy, counseling, or others)
Part XII:	**Least Restrictive Environment** (placement and rationale for the decision)
Part XIII:	**Placement Decision**
Part XIV:	**Referral for Consideration of Alternative Placement**
Part XV:	**Specialized Transportation**
Part XVI:	**Summary**

Video Example 5.2

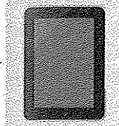
Watch this video, which includes an adaptive keyboard, a high-tech assistive device. How does this device make the classroom more inclusive?

Assistive technology can help children accomplish their tasks by increasing their independence and allowing them to participate more fully in classroom activities. Items that use no electronic components, such as pencil grips, non-slip placemats, and study carrels, are examples of low-tech assistive technology devices. Audio books, calculators, and timers are examples of mid-range technology. For children unable to move freely from place to place, motorized scooter boards, wheeled go-carts, and wheelchairs are necessary assistive

devices. Other more complex devices that read printed books aloud and talking computer programs are available for children who have problems reading and writing. A keyboard with large keys, a specially designed mouse, and software that enlarges screen content are examples of modifications that allow people with various disabilities to use computers.

The IEP team should carefully consider any assistive devices that may be necessary to help a child move, communicate, and learn most effectively. Choosing and modifying these technologies can be challenging, but increasingly sophisticated computer and other assistive devices are enabling individuals with disabilities reach their full potential.

MEDIA MATTERS



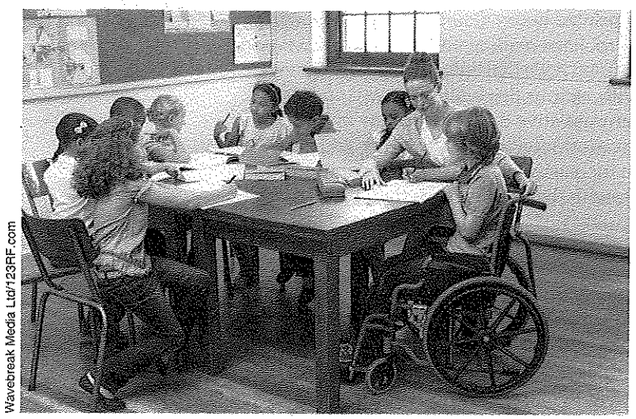
Touch-screen manipulation of digital equipment is now commonplace in our society, and we all know that individuals with tablets, smartphones, and e-readers would be quite lost without this time-saving feature. But for children with disabilities, the rewards are even more pronounced. When any computer screen has the capability to accept touch in lieu of key strokes or mouse clicks, the child learner is given more control and greater opportunity. When less time and effort is required for manual dexterity, more time is given for practicing skills, gaining information, experimenting with the equipment, and appreciating cause and effect. Touch screens have helped many young children, especially those with physical disabilities, participate more fully in the learning process.

One controversial form of technology is the cochlear implant device, which can restore hearing for children who are deaf. The implant bypasses the damaged part of the ear and transmits digitally processed sound directly into the cochlea. The surgery is best performed on very young children. Many members of the deaf community, however, feel that the cochlear implant device threatens the deaf way of life, which is based on American Sign Language. The debate continues on this issue, but other uses of technology are less controversial, and children with disabilities benefit from the advances being made in many areas of assistive technology.

Inclusion

As they waited for the IEP meeting to begin, Alex and Deena, parents of third-grader Amelia, shifted uncomfortably in their chairs as the seven professionals chatted and laughed among themselves. Soon the parents were handed stacks of paper, and they listened as the special educator, school psychologist, counselor, and speech and language specialist gave their reports of the evaluations they had conducted with Amelia. Alex and Deena were overwhelmed with the unfamiliar terms and acronyms, and bewildered by the process. Fortunately, Amelia's classroom teacher recognized their discomfort, helped slow down the proceedings, and translated the unfamiliar terms to concepts they could understand. Finally, Alex was able to say, "So the bottom line is, Amelia has been diagnosed with a language impairment, right? And she will start receiving special education services?" One of the team members quickly assured the parents that this was the case, but reminded them that Amelia would still be in the same classroom and receive her accommodations as part of the ongoing classroom instruction. She would also have some small group language therapy on a regular basis. Alex and Deena sighed and signed the IEP, hoping that this was the best course of action for their struggling child.

In the past, Amelia might have been placed in a self-contained special education classroom with other children with disabilities. Today, however, inclusion in a classroom with typically developing children has become the norm for children with disabilities. Inclusion does not have one specific definition; it can and should be defined by the


Wavebreak Media Ltd/123RF.com

A teacher's attitude toward inclusion is the most important influence on the success of a child with disabilities.

needs of each individual child. Many children remain in general education all day, while others may receive some services in a more specialized setting. However, full inclusion is always the goal, because:

1. Separation is inherently stigmatizing to children with a disability.
2. Children with disabilities benefit from interaction with nondisabled peers.
3. Children placed in separate classrooms function at a lower level and with lowered expectations, and lower performance becomes a self-fulfilling prophecy.

Others argue that not all children with disabilities benefit from full inclusion, and state that the environment should be appropriate for the child. Some children really need the small group size, close monitoring, and individualized interactions that a separate classroom provides. Other children may require instruction in a special school, or may need to be educated at home for a period of time. See Figure 5-4 for the continuum of possible placements meeting the criteria for the LRE.

Critics of full inclusion also consider the needs of students without disabilities, whose learning may be interrupted by the socially inappropriate or disruptive behavior of some children with disabilities. Although the issue of full versus partial inclusion continues to be debated in professional literature and in the courts, general educators can expect to have children with disabilities in their classrooms on a full- and part-time basis for the foreseeable future. The principle of the LRE always makes the general education classroom a desirable option or goal for the majority of children with disabilities.

Video Example 5.3

Watch this video to gain some insight about the progression from self-contained settings for children with disabilities to the inclusion model that is prevalent today. What are the benefits of the inclusion model?

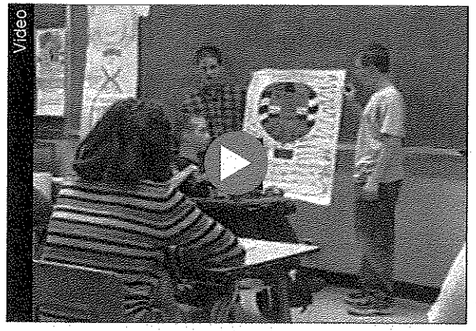


FIGURE 5-4 Continuum of Possible Placements for Children with Disabilities

Most Restrictive to Least Restrictive
Home or hospital placement
Full-time placement in a residential facility
Full-day placement in a special education school (public or private)
Full-day placement in a special education class
Full-day placement in a special education class with social integration with the general school population
Part-day general class placement and part-day special education class placement
Part-day general class placement and part-day resource or itinerant services
Full-day general class placement with instruction delivered in the regular class by a specialist
Full-day general class placement with consultation services for the teacher

Source: US Department of Education (2011). *Thirtieth annual report to Congress on the implementation of the Individuals with Disabilities Education Act.* Washington, DC: US Department of Education.

Welcoming a Child with Disabilities into the General Education Classroom

The teacher's attitude is the single most important influence on the success of a child with disabilities placed in a general education classroom. Fortunately, we find that teachers' attitudes about inclusion are becoming more positive. In addition to this positive attitude, however, teachers need training and support to best meet the needs of children with disabilities assigned to their classrooms. They also must learn how to work collaboratively with special educators and other specialists who will be part of the child's team.

EXAMINE YOUR BELIEFS AND PRACTICES

To learn about specific disabilities, select one that you want to learn more about, and conduct an online search. Develop a one- to two-page fact sheet detailing some of the characteristics of this disability, ways that the general educator can work successfully with children with the disability, and supports that are available for their parents.

Once assigned a child with a disability, general education teachers will need to find out as much information about the child as possible, and may want to become educated about the specific disability. The child's IEP (see Figure 5-3 for the components of the IEP) is an important source of information. Teachers may also need to prepare typically developing children for the presence of a child with disabilities in their classroom, particularly if the child uses a wheelchair or displays behaviors that are atypical for the grade level. Helping the children recognize that everyone has strengths and weaknesses is an appropriate starting point to ensure all learners will be welcomed.

Through their positive attitude and warmth, teachers will model acceptance of all individuals and set a respectful tone. Some teachers find that children's literature is helpful in introducing different kinds of disabilities and facilitating discussion. (See the bibliography of children's books in this text for suggested titles.) Others follow this

discussion with a conversation involving the child and his or her parents, as appropriate. For example, children who use a wheelchair or other assistive devices can demonstrate how the devices operate and how they help them move and learn.

Although Georgie was more than 6 years old when he entered Ms. Williams's kindergarten class for the first time, he was very small for his age, and very busy. Within minutes, he was running around the classroom, shrieking and laughing. As the days went by, it became clear that Georgie would have difficulty participating in the kindergarten curriculum. Ms. Williams began to have him sit on her lap during circle time, which calmed him down and helped him focus. When other children wanted to sit on her lap as well, Ms. Williams gently reminded them that they didn't need this assistance. Soon, the other children were helping Georgie through the daily routines, and he began to sit in the circle with a friend on either side holding his hands and reminding him about the rules. Later in the year, Georgie was diagnosed with a disability, and began receiving services from the special education teacher, Ms. Britt. She was delighted to see that Georgie was a fully accepted member of the kindergarten class. What also pleased her was the empathy the other children showed for Georgie, and how proud they were of his accomplishments.

Although the debate continues about the merits of full and partial inclusion, it is certain that all children benefit when children with and without disabilities attend school together. Special educators who work carefully with general educators in preparing for inclusion and offer support during its implementation can help promote the positive attitudes essential for a successful experience. Together, the general educator and special educator will determine how to help the child understand and follow class rules and routines, and to fit in socially with the other children. Depending on the nature of the disability, accommodations and modifications may need to be made in the physical environment and in academic expectations (see Figure 5-5).

FIGURE 5-5 Strategies for Working with Children with Disabilities

- Set high but realistic expectations for each student.
- Get to know the students' strengths and needs, and use those to plan instruction.
- Use flexible grouping for differentiation.
- Model acceptance, respect, and patience.
- Demonstrate and model instructions.
- Phrase directions in the positive (for example, say, "build with your blocks, please" instead of "stop throwing your blocks").
- Give instructions in one or two steps at a time.
- Use cooperative learning strategies, paired learning experiences, and buddies for support.
- Create a community of learners who care about and support each other.
- Use visual supports, especially picture schedules.
- Ensure that children are provided wait time to respond.

Source: Based on Merz (2009)

The general education teacher will need to become very familiar with each child's IEP, particularly Part VIII, which spells out the accommodations children require in order to be educated with nondisabled children to the maximum extent appropriate. The most common adaptations include providing children with shorter or different assignments, scribing children's ideas, reading instructions and tests to them, and/or providing extra time for assignments and tests. Other supports include slower-paced instruction, more frequent feedback, audio books, use of a computer for activities not allowed to other children, and the ongoing support of a special education teacher, instructional assistant, and/or personal aide. Touch-screen technology has opened up possibilities for children who have found conventional classroom manipulatives (pens, books, paper, etc.) difficult to work with. A well-functioning team of skilled professionals can make all the difference in ensuring that the inclusion of children with disabilities is a positive experience for all concerned.

IDEAS FOR YOUR CLASSROOM

Making Inclusion Work

Keep in mind that the instructional program in an inclusion classroom will not be exactly alike for all children, but will be designed to help all children learn. Even in classrooms where no children have diagnosed disabilities, you should think about differentiating your instruction for the various levels of ability and experiences that children bring with them. The suggestions for working with children with disabilities listed in Figure 5-5 are good teaching strategies for all children. Remember that the children you teach who have disabilities are more similar to their peers than different from them. And finally, recognize that fair is not necessarily equal in terms of the instructional program. ***Fairness means that every student gets what he or she needs!***

Sustaining Parents of Children with Disabilities

You will find many general strategies for collaboration between schools, families, and communities throughout this text. Professionals working with parents raising children with disabilities, however, have some unique challenges in establishing and maintaining positive relationships with these families. The importance of a trusting relationship between educators and parents in these situations can hardly be overstated. Families are an integral part of the educational process, from referral through evaluation, placement, and reevaluation. Parents are equal partners in decision making for their children.

Teachers need to be friendly and optimistic when working with parents; remember, this is their child! Remember to have patience with parents, because they are often working through the process for the first time. That includes being tactful and responsive when dealing with parental concerns. Be open to their suggestions and listen carefully; the children are in school for part of a day … they are their parent's child forever.

Teachers should use a family-centered approach to work successfully with children with disabilities. This includes acknowledgment of and respect for each family's strengths, culture, language, and ability to make decisions for their child, even if these decisions differ from those the professionals would choose. As mentioned earlier in the chapter, establishing a relationship with parents starts with getting to know them and allowing them to get to know you. Before attempting to communicate about sensitive topics, make a sincere attempt to establish rapport with the family through positive phone calls and general meetings.

IDEAS FOR YOUR CLASSROOM

Ongoing Communication with Parents

Once you have established a positive relationship with parents, it is essential that you maintain ongoing communication through whatever means you have established. Just as you might share tips about successful homework strategies, you will also want to ask the parents what is going well at home and make certain that you are aware of their concerns. You will also want to ask for their suggestions about ways to work successfully with their child in school. Remember that they are the experts on their child, but you can share what you have learned about children through your experiences.

Most children with disabilities clearly benefit from a reading routine at home. For example, you may want to suggest that parents put aside a short amount of time to read to or with their child on a regular basis. You can also suggest the value of board games for helping children build their math and reading skills. A family game night at school is a great way to introduce all families to the benefits of playing together. Remember, just as children with disabilities are much like their typically developing peers, so are their parents like all parents.

One area that can be particularly challenging for parents of children with disabilities is getting their children to do homework. Without some good strategies and support, families may be faced with tantrums and meltdowns at homework time. Urge families to allow their children to have some vigorous play, a healthy snack, and a chance to relax before attempting homework. Make sure the family knows that you are willing to work with them as needed to get the homework done. Besides modifying homework as appropriate to the child's needs, share the suggestions in Figure 5-6 with parents so that they know you are eager to support their efforts at home.

Ongoing communication is particularly helpful concerning homework, so establish how the family would like to stay in touch. Depending on parents' experience and interest with digital devices and formats, you may find that e-mailing, texting, and phoning will serve nicely for rapid communications to assure or alert parents on changes. But the well-tested homework notebook that goes back and forth in a child's backpack is still a trusted way to keep parent and teacher in touch.

FIGURE 5-6 Helping Parents Help Their Child with Homework

Share the following suggestions with parents to help them ease homework hassles, which can be particularly difficult for children with disabilities.

Find the Right Place and Keep It Consistent	Kitchen table, floor, desk, or any other location that works
Organize Technology	Use a word processor; allow music if it helps your child focus; use a paper with an opening so your child sees only one math problem at a time
Stay Involved	Show your interest by being nearby; read or rephrase questions as needed; offer little rewards as small amounts of work get done
Make Adjustments	Work with your child's teacher if the work seems too easy or too hard, and find out if you can scribe for your child or offer choices of assignments
Stay Connected	Develop a plan for making sure your child brings home accurate homework assignments and all needed material by establishing a system with the teacher and a contact with a family member of another student in the class to double-check assignments; make certain your child's homework is returned to school in a systematic way

Check Your Understanding 5.5
Click here to gauge your understanding of the concepts in this section.

COMMUNITY SUPPORT FOR CHILDREN WITH DISABILITIES

Although schools play an important role in educating children with disabilities and supporting their parents, the larger community also offers resources for these children and their families. Teachers and other professionals can be instrumental in helping link families with needed services available in the community, and also with online organizations and resources.

As Laverne and Reggie sat in the stands watching their 9-year-old daughter, Latisha, dribble the ball down the court and successfully sink a basket, they grabbed each others' hands and leaped to their feet, cheering. The idea of Latisha, who was diagnosed with autism at age 2, competing in a basketball tournament was something they had never even considered a few years ago. Special Olympics had made it possible.

Fortunately for Latisha and her family, her special education teacher had informed them about the opportunity for Latisha to participate in Special Olympics. With over 32 summer and winter sports available in more than 200 programs throughout the United States, Special Olympics has given individuals with intellectual disabilities the chance to be part of a team and compete with others of similar ability. Besides this national organization, many local communities also provide sports and recreational activities geared to children with disabilities. These children may need before- and after-school care, occasional evening babysitting, and chances to participate in community events and activities with typically developing peers.

Teachers and other school personnel who are knowledgeable about their community can help parents and children access these out-of-school opportunities. They can also help families connect with other parents raising children with the same disability in the local or online community. Finally, community agencies have a responsibility to reach out to families raising children with disabilities to alert them to the resources available for them and their children.

Helping Find Support for Parents

As a warm and sympathetic person who genuinely cares about children with disabilities and their families, you may find yourself in an uncomfortable position when parents share personal information about family issues that are beyond the scope of their child's education. In these cases, it is particularly important for you to have support resources that you can suggest to the parents. The school psychologist, social worker, or counselor can be a great help in generating a list of community services that can be accessed by families. Helping parents learn how to obtain needed help for themselves and their children will enable them to meet their ongoing needs.

You may want to suggest resources and support to parents who seem stressed and overburdened with the responsibilities of caring for their child with a disability. Other parents may need guidance in providing the best parenting. Disability rights

organizations, respite programs, parent networks, and family resource centers are found in many communities. Although you may have many ideas to share with families about parent-to-parent support groups and online communities that address issues related to parenting children with disabilities, remember that the family must decide whether or not they wish to participate in such organizations and activities. The role of the professional is to provide the information and respect parents' decisions about how they choose to utilize it.

It is important to remember that families find support in many ways. Some will choose to participate in formal networks of parents, professionals, and helping agencies; others will rely on informal networks of extended family, friends, neighbors, and members of their spiritual congregation. Many families will utilize available support from both the formal and informal networks that they establish. Over time, their needs may change, and they will establish new connections and discontinue participation in some groups.

Lanisha entered the community center to attend the Parents of Children with Autism support group, just as she had done many times over the past few years. She remembered the first time she attended, shortly after her son, Evan, had been diagnosed with autism at age 3. Lanisha remembered all of the questions and fears, and how just listening to other parents helped ease her nerves. For the first time in years, Lanisha was nervous as she entered the room—not because of her questions and fears, but because after years of participating, she was now co-leading the group. She hoped she would be able to assist the parents sitting in the room just as she had been helped all those years ago.

As Lanisha's story indicates, parents raising children with disabilities often develop great expertise in working with other children with the same disability, and with the parents of those children. Their input and perspectives are helpful to other parents coping with the same issues and to professionals. So, although it is important to provide parents with resources for support, also remember that many parents can be support persons as well.

Denis Kuvaev/Shutterstock

Children with disabilities often participate successfully in games and activities.

Children with Disabilities in the Community

As the earlier vignette about Latisha and the Special Olympics basketball team indicates, children with disabilities can participate in community activities that are planned just for them. Various community organizations, spiritual groups, and family support networks often plan activities, field trips, recreational classes, dances, and other gatherings geared to children with particular disabilities. Some day and residential camps also offer summer programs that meet the needs of children with various physical, behavioral, and cognitive disabilities. All these activities help children with disabilities make friends and increase their social networks.

As important as these opportunities are, however, it is essential that children with disabilities are included in the general community activities provided for all children. Consequently, we are increasingly seeing children with disabilities participating in clubs, scout troops, before- and after-school child-care programs, sports teams, performing arts groups, and other activities alongside their typically developing peers. Building community connections fosters children's sense of belonging, which helps them develop friendships, social skills, and the support system necessary to partake fully of community life.

Throughout their childhood years, children with disabilities will transition from one setting to another. Children diagnosed early in life transition from preschool and early intervention services to the elementary school. Later, they transition to middle and high schools, and finally, they must make the transition to adult lives. For those children who have actively participated in the community, these transitions are less traumatic, because the children have other relationships and activities that continue even when their school setting changes.

Early intervention, inclusion, and the general change in society's attitude toward persons with disabilities that has occurred over the past 40 years have made a huge difference in the opportunities children with disabilities have to participate in the mainstream life of childhood, both in and out of school. With advances in technology and increased awareness of the benefits of inclusion for all children, children with disabilities will have even greater chances of developing to their full potential within their families, schools, and communities.

Check Your Understanding 5.6

Click here to gauge your understanding of the concepts in this section.

Summary and Review

Federal legislation over the past 40 years has had a profound effect on children with disabilities and their opportunities for education. Early identification of disabilities and developmental delays and the provision of intervention services for infants, toddlers, preschoolers, and their families, have helped many young children acquire the skills and behaviors that allow them to participate in the activities typical for their age group.

Most children with disabilities benefit from being included with their typically developing peers for as much of the school day as possible, and their peers will also gain from their presence. Children with disabilities also profit from participation in community activities designed for all children, and teachers can play an important role in helping connect families and children to resources and supports available in school, in the community, and online.

How Does Learning About this Topic Help You Become a Better Teacher?

One of the most important aspects of the Individuals with Disabilities Education Improvement Act (IDEIA) is the principle that parent collaboration is essential in the process of determining the best educational setting for the child. Parents have expert knowledge of their child, and their perceptions of their child's strengths and needs are important to the process of evaluating and placing their child. Effective collaboration requires mutual trust and respect. As a professional, you must be especially sensitive in helping parents negotiate the complex process of identifying children with special needs and the legal procedures involved in making a placement. For parents, school meetings can be an alphabet soup of acronyms that they may not understand (e.g., IFSP, IEP, FAPE, LRE). The law requires a translator for parents who do not speak English, but the sensitive teacher will also find ways to make the complex process understandable for all parents.

teachers, and child-care professionals must be aware of the dangers and hazards, and guide children carefully. Our task here is to show how these potential problems affect growth and learning, and to seek ways to minimize risks.

For many, protecting children relates most closely to safeguarding children from abuse and neglect. Today, we take for granted the child protection system that exists in every jurisdiction in the United States. Before the 1960s, however, protection of children was handled by non-governmental societies scattered across the country. The New York Society for the Prevention of Cruelty to Children was the first of these charities, and was modeled after a similar organization that protected animals. It wasn't until the 1960s that child abuse emerged from the shadows as physicians started to raise awareness and media reports captured the public's attention. As a result, reporting laws went into effect, and the foster care system was developed as a safe haven for children who had been abused.

It is hard to imagine today, but less than 100 years ago, American children as young as age 7 were part of the workforce. They worked in factories, farms, and mines doing the tasks of adults, but were paid much less. Their working hours left little time for play or school. It took the efforts of many people—concerned citizens, educators, church parishioners, and labor groups—to press for reforms, which finally resulted in a national child labor law in 1938. This law set the minimum employment age at 16 during school hours, 14 for certain jobs after school, and 18 for dangerous work. Unfortunately, children of migrant workers are not protected by these laws, so child labor remains a problem among that population (*Children in the Fields*; National Farmworkers' Ministry, 2011).

Protecting children from violence is a cause that has united families, schools, and communities in rallying to have national, state, and local laws passed that limit certain kinds of guns and ammunition, and to require background checks on people who want to purchase guns. Yet, despite the response to the tragic mass shooting at Sandy Hook Elementary School in Newtown, Conn., in 2012 that called for more effective gun control measures, little has changed. Every day, forty-eight children and teens are shot in murders, assaults, suicides and suicide attempts, unintentional shootings, and police intervention, and there were sixty-four school shootings in 2015. Powerful lobbying by organizations such as the National Rifle Association have blocked the development of effective gun control regulations in the United States that might prevent additional tragedies (*Key Gun Violence Statistics;* Brady Campaign to Prevent Gun Violence, 2015).

Like gun control, many of the other issues that we deal with in this chapter are controversial and complex. Resolving the childhood obesity epidemic, food instability in poor families, and the health issues related to improper nutrition and lack of exercise will take a concerted effort among many parts of society. And while violence and bullying have long been part of society, the dangers inherent from cyberbullying and other media dangers were unheard of until recently. It is beyond the scope of this text to delve deeply into the history of the protections of children that have been put into place over the years, but it remains a constant that change usually occurs through partnerships among the three social settings. These problems may seem overwhelming, and you may wonder what impact you can have in trying to solve these issues. As a professional, your first responsibility is to build your awareness of the potential dangers that the children you teach may face, and to commit to doing what you can to keep youngsters safe and healthy. Aim to link your efforts with the families and the communities who have a huge stake in these same children.

Positive educational outcomes stem from settings that are nurturing and safe. So, parents and caregivers have a primary responsibility to take care of the basic physiological and psychological needs of their children and keep them safe. Nurturance spreads across most areas of human life, and a large part of it involves teaching life skills that will protect children and prepare them for later life.

EXAMINE YOUR BELIEFS AND PRACTICES

This may be a good time to think back to your own early school years and reflect on how people at your school protected you. Can you identify some of their actions? Do you think those practices exist in the schools you see today?

SAFETY, MENTAL HEALTH, AND PHYSICAL WELL-BEING

Karen's popular child-care center has been tense this fall since Jason joined the group in September. Jason, an overweight and unhappy child, lives with his grandmother, who has taken over his care because Jason's young parents relinquished most of their parenting responsibilities due to their opioid addiction.

Jason came to the center at the request of the Children's Health Services office, where it was felt that he could benefit from the program. But Jason has been a challenge from the first week, when he destroyed two projects at the center and shoved two boys into the swing set. Because of his aggressive behavior, most of the other 4-year-olds reject him and call him mean. This intensifies Jason's aggression, and when staff members approach him after his bullying acts, Jason says he didn't do anything, and tries to run off. He is disciplined frequently by being placed in the time-out chair.

Staff members have noticed that when Jason's grandmother picks him up, she negotiates almost all demands with candy bars. She often slaps his head if Jason resists her follow-up requests. But she says, "Oh, he'll outgrow it," when staff members request help in controlling his aggressive acts.

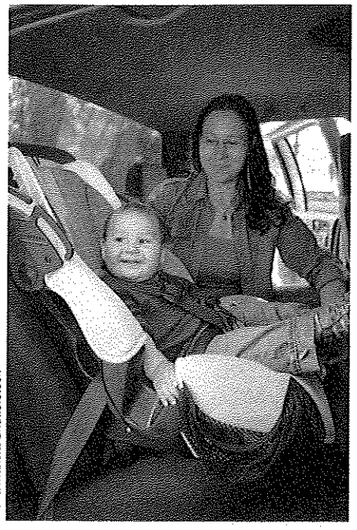
Karen is worried about Jason's health and his effect on other children's behavior, on staff members' morale (one part-time assistant quit after Jason punched her when she tried to prevent him from flinging toys), and on Jason's worsening social skills. "I think we'll have to drop him at holiday time unless we get some help from Children's Health Services," she said at the end of a tiring week.

A social worker from Children's Health Services did visit the next week, and persuaded the staff to develop ways of involving Jason's grandmother in their concerns. It is only a beginning, but the center's personnel have started a conversation on using more positive discipline methods at home and at the center. They have also arranged for Jason to get some play therapy to help him deal with the absence of his parents. At the center, the teachers are developing a healthy habits curriculum with a focus on nutritious foods and exercise. Protection for Jason and the other children has become a dominant concern for all participants at Karen's center; so other program matters will have a lower priority until this issue is resolved.

The broad areas that we discuss in the following sections are physical safety and health and wellness.

Physical Safety

As the situation in Karen's child-care center in the vignette illustrates, caregivers have a primary responsibility to keep children physically safe. Some children also need



Mona Makela/Shutterstock

Parents and caregivers must provide safe environments and help children learn safe practices.

protection from themselves. Although the situation is uncommon, some children have disabilities that require special effort to ensure their safety. Children with mood disorders, learning disabilities, impaired mental functioning, and physical disabilities may require more supervision and monitoring by caregivers to ensure their safety. Collaboration with community agencies such as Children's Health Services can provide needed information, support, and respite for caregivers. Another resource is **Child Find**, a process designed to locate, identify, and evaluate children who may require early intervention or special education services.

Parents and caregivers have a responsibility to provide an environment that is as free from hazards as possible and gradually help children learn ways to keep themselves safe (American Academy of Pediatrics et al., 2011). Childproofing an area for toddlers to avoid dangers and problems is assumed by most adults, but this same attitude should continue as parents and caregivers work with older children. Measures need to be taken to prevent injuries from falls, burns from fire and other heat sources, poisoning from toxic substances, and drowning in bathtubs or pools. Figure 6-1 is a general listing of potential dangers in and around the typical home and the source of most child injuries (National Safety Council, 2017).

There are other hazards to consider in the home, school, and community related to safe handling of food, playgrounds, pesticides, and exposure to allergens, sun, or lead paint. Children must also be protected from traffic hazards and taught rules about how to cross streets safely. All teachers and caregivers must develop the habit of appraising situations and anticipating problems or dangers. Unintentional injuries to children under age 5 rose 10 percent between 2007 and 2012, after falling for much of the prior decade. Research suggests that caregiver distraction while using their smartphones may relate to this increase. Children were also more likely to engage in dangerous behaviors such as throwing sand, walking up a slide, sliding headfirst and jumping off moving swings when caregivers were distracted.

FIGURE 6-1 Home Hazards for Young Children

Burns/smoke	Heat sources such as fires, stoves, appliances, matches, and hot liquids
Inhalation	Smoke from house fire
Wounds	Knives, scissors, tools, and appliances
Injuries	Machines with sharp, hot, or moving parts
Burns/shock	Electrical sockets, power cords, appliances, and faulty lines
Drowning	Sink, tub, pool, pails (children can drown in as little as 1 inch of water)
Death/wounds	Firearms
Suffocation	Fluffy bedding for babies, plastic bags, old refrigerators, and trunks
Choking	Small toys, household items, food (hot dogs, nuts, grapes, popcorn)
Poisoning	Carbon monoxide, cleaning fluids, insecticides, medicines, disinfectants, mislabeled items, solvents, and liquor
Falls	Unsecured windows, ungated stairs, sitting on counters
Bites/scratches	Dogs, cats, and other pets

Parents and caregivers need to be mindful of how distracting their electronic devices can be, and more attentive to children's safety. Keep in mind that injuries are the leading cause of death for children.

While protective measures and appropriate supervision are put in place, caregivers also need to educate children about potential dangers without preventing a certain amount of risk. Risk taking within an environment that is free from hazards makes play enjoyable and leads to growth in physical, social, emotional, and cognitive areas of learning.

Society expects parents to be the primary advocates, protectors, and supervisors of their children. Most families, however, regularly depend on authorities to alert them to threats—for example, to notify them when the heat index is dangerously high or treacherous weather is approaching. We also rely on governmental agencies such as the Environmental Protection Agency (EPA) to safeguard our air and water supplies. As this text was being revised, efforts to scale back the regulatory efforts of the EPA were underway, undermining years of progress in improving the quality of air and water sources. This may be another area where families, schools, and communities will need to work together to ensure that our natural environment remains safe for our children and future generations.

Rob Judges/Pearson Education Ltd.

Frequent inspection of play areas will help ensure that grounds do not contain dangerous objects.

Child-care centers and schools are regularly inspected to ensure their indoor and outdoor environments are physically safe for children, but teachers share responsibility for ongoing scrutiny of the environment to make certain hazards are not present. Of course, we would not knowingly leave poisons in a place accessible to children, but hidden, long-term dangers of exposure to the chemical toxins in pesticides, insect repellents, and other substances used in yards, parks, and playgrounds are under increasing scrutiny as well (Rivkin, 2013).

Playground safety is of particular concern, as equipment and protective surfaces must be well maintained by the appropriate agencies to ensure children's well-being. The National Program for Playground Safety has a kid checker form on its website aimed at elementary-age children to help them spot playground safety issues. Because school play areas are often shared by the larger community, some may need daily inspection to make sure the grounds have not been littered with glass or other potentially dangerous objects.

Other safety issues to consider in the outdoors concern the dangers of overexposure to the sun, allergic reactions to stings, and asthma attacks brought on by strenuous play. By working with families to make certain children have sunscreen and hats, and by having and knowing how to administer an EpiPen when an allergic child has been stung or an inhaler when a child starts to wheeze, you will be doing your part to ensure children's well-being outdoors.

IDEAS FOR YOUR CLASSROOM

Preparing for an emergency

No matter how carefully you monitor children and their surroundings, accidents and emergencies will occur. Prepare yourself by doing the following:

- *Become certified in cardiopulmonary resuscitation (CPR) and learn how to do the abdominal thrust procedure (Heimlich maneuver).*
- *Assemble and keep with you while outdoors and on field trips a first aid kit with emergency instructions and any EpiPens or inhalers that individual children may need.*
- *Store important numbers in your phone's memory, such as poison control, the local child protection agency, school number, and the home numbers of children with severe allergies, asthma, and other health needs.*
- *Teach your children how to call 9-1-1 in case you are incapacitated.*

Providing for Wellness

Good health is a factor of physical, mental, and social well-being, not just the absence of disease or infirmities. Teaching children healthy practices is considered part of normal child rearing, and most parents readily accept responsibility for promoting the health of their young. Most health concepts that parents focus on grow out of situations associated with everyday living. Families attend to medical checkups and immunizations for their children, and schools reinforce this by requiring documentation that they are up to date in order for children to attend school. Families ensure that their children live and play in smoke-free buildings that are well ventilated and well lighted. They are attuned to mental health evaluations when symptoms appear. Schools and communities have the same objectives for children, and provide many support systems to enhance children's health.

Families living in poverty or coping with serious financial issues may need greater support. Children in these stressful circumstances frequently suffer from chronic health problems, accidents, and inadequate nutrition. Smoke pollution, crowded living conditions, poor sanitation, unhealthy or inadequate food, and minimal skill in managing resources may be other factors endangering children. Some problems stem from ignorance about basic home maintenance, some come from inadequate planning and substance abuse, and many come from the inability of parents to secure and follow through on available care and help from social agencies. Illness and health problems become all too often a function of income.

FOOD INSECURITY In many poor households, families struggle to afford the food that they need, and food insecurity affected an estimated 12.7 percent of American households in 2015. These families were food insecure for at least some time during the year, meaning they lacked access to enough food for an active, healthy life for all household members. While this is down from 14 percent in 2014 and the prevalence of very low food security declined to 5 percent from 5.6 percent in 2014, the resulting lack of proper nutrition affects children in many ways that are detrimental to their physical and mental health (Coleman-Jensen et al., 2016). And in some cases, poor nutrition had an impact prior to birth due to the mother's poor nutrition before and during pregnancy.

Hungry children are more likely to suffer from anxiety and exhibit behavioral issues in schools. They tend to get sick more often than their peers and become hospitalized due to their inability to fight off disease. The National School Breakfast and Lunch Programs were established in 1975 to provide nutritious meals for children at the lowest price possible. For a child to receive a free breakfast and lunch, household income must

be at or below 130% of the poverty level ($26,813 per year for a family of three), and to receive reduced-price meals, income must be between 130% and 185% of the poverty level (up to $35,317 per year for a family of three). The breakfast and lunch programs are designed to provide about half or more of the nutrients children need each day. The percentage of children eligible for free or reduced-price lunch (FRPL) is often used as an indication of the poverty level in a school, with high-poverty schools defined as those where more than 75 percent of the students are eligible for FRPL, and low-poverty schools defined as those where 2 percent or less of the students are eligible.

Other food and nutrition programs offered by the federal government and administered by schools include the Afterschool Nutrition Program, the Summer Nutrition Program, and the Fresh Fruit and Vegetable Program. Families can apply for the Supplemental Nutrition Assistance Program (formerly the Food Stamp Program) to help them purchase food for their households. As a teacher, you are in a good position to make sure that families know about and apply for these programs, if they are eligible.

PROVIDING GOOD NUTRITION No matter the income level, families who know about healthy food use and preparation, the basics of nutrition, and how to deal with allergies have an advantage in helping their children eat appropriately. Child-care centers and schools also play a role in providing healthy choices for children and educating children about good nutrition. When health and nutrition standards are preserved, children are served meals that focus on a healthy plate (see Figure 6-2) with an emphasis on fruits, vegetables, grains, protein, and dairy. MyPlate, MyWins is a new federal initiative focused on helping families develop a healthy eating style to ensure they get all the nutrients they need. As a teacher, you may find using MyPlate's tips, tools, and resources will help you teach about nutrition and share important information with families. Check out #MyPlateMyWins on social media or search online for "Choose My Plate." From the home page of the website, search for "What are MyPlate, MyWins" for more information of healthy eating habits:

- Reduce the use of processed foods containing high levels of fat, salt, and additives
- Reduce the use of sweets and soft drinks
- Provide sensible snacks such as fruit, vegetables, and whole-grain baked goods

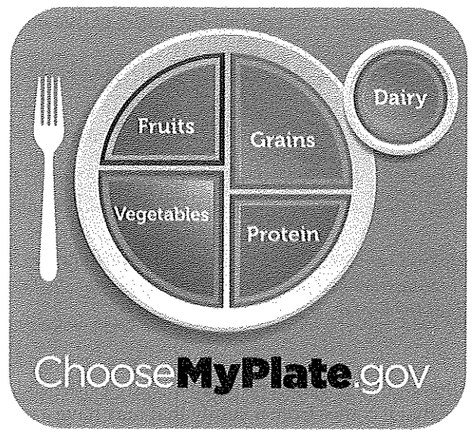


FIGURE 6-2 What's on Your Plate?
Source: USDA Center for Nutrition Policy and Promotion (2017).

Lifelong eating habits are formed during the early years, and families and child-care providers play an important role in introducing new foods and establishing a relaxed eating environment. Hand washing, teeth brushing, and caring for bodily functions are other healthy habits learned in the home that are reinforced in child-care settings and schools.

OBESITY IN CHILDREN Obesity is defined as having excess body fat, while overweight is defined as having excess body weight for a particular height from fat, muscle, bone, water, or a combination of these factors. Body mass index, or BMI, is a widely used screening tool for measuring both overweight and obesity. This tool is preferred for measuring children and young adults (ages 2–20), because it takes into account that they are still growing, and growing at different rates depending on their age and sex. Health professionals use growth charts to see whether a child's weight falls into a healthy range for the child's height, age, and sex. Children with a BMI at or above the 85th percentile and less than the 95th percentile are considered overweight. Children at or above the 95th percentile have obesity.

Obesity is a major problem for America's youth, and you most likely recognize this from the extensive coverage in media. The percentage of children who are overweight or have obesity has more than tripled since the 1970s. About 1 in 5 school-aged children (ages 6–19) is obese (Fryar et al., 2014). These alarming statistics point to the need for families, with help from schools and communities, to address problems of overeating, poor food choices and insufficient exercise.

The obesity epidemic has implications for the emotional and physical health of children, now and in the future (Centers for Disease Control and Prevention, 2013). Prediabetes, bone and joint problems, sleep apnea, high cholesterol, and high blood pressure are more common in obese children and put them at risk for serious adult diseases. Overweight and obese children may have low self-esteem, negative body image, and depression, and may become the targets of teasing and bullying. Long-term health effects include adult obesity and its related problems such as heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis.

Paul was restocking shelves in the small rural grocery when he was approached by two huffing and excited young boys with large bags of potato chips under their arms. "Hey, mister," said the 8-year-old, "there's no big bottles of cola on the shelf over there. Mom's lettin' us pick out our lunch, and we want cola."

Paul smiled at the youngsters and said, "Sure, I'll get some," and he went to the storeroom to get liter bottles of Coca-Cola. Upon returning, Paul noticed that their mother had arrived with a grocery cart heavy with more soft drinks, stacks of bread, frozen dinners, and cold cuts. He handed bottles to the two boys, saying, "Is this what you needed?"

"Yep," replied the 7-year-old. "Okay, Mom, we got our lunch. Let's go!" Then the boys and their mother, all noticeably overweight, moved slowly along the aisle to the checkout counter.

At that moment, Paul noticed the large sign showing healthy lunches that the Healthy Community Project volunteers had posted near the potato chip shelf. Neither potato chips nor cola is pictured on the poster.

This vignette illustrates the weight problem already evidenced in these young children, and we surmise that it comes from a family that may have a genetic predisposition to obesity and struggles to implement good dietary practices. But the issues related to child obesity go beyond the individual family, and are part of a larger unhealthy nutrition environment. Low-cost processed foods, sugary drinks in increasingly larger sizes,

fast food, access to unhealthy snacks in most social settings, and the extensive advertising of processed foods all are part of the problem. The healthy food choice is not the easy or most accessible choice. Additionally, many factors have led to a decrease in the activity level of children both at home and at school, an issue we will address elsewhere in the text. Table 6-1 provides some basic strategies that teachers can share with children and parents interested in healthy weight loss.

The obesity problem could continue for years, and will be costly for individual children, their families, and the community unless action is taken. Good food choices and nutrition make excellent topics for family, school, and community collaborations. Units on nutrition fit well in the Health Curriculum and, when initiated by a school, can easily extend to families and community agencies for support. This can lead to advocating for healthy school lunches, appropriate snacks in school vending machines, and greater awareness of the marketing of food. Figure 6-2, which shows the US Department of Agriculture's "What's on Your Plate?" image, provides a good starting point.

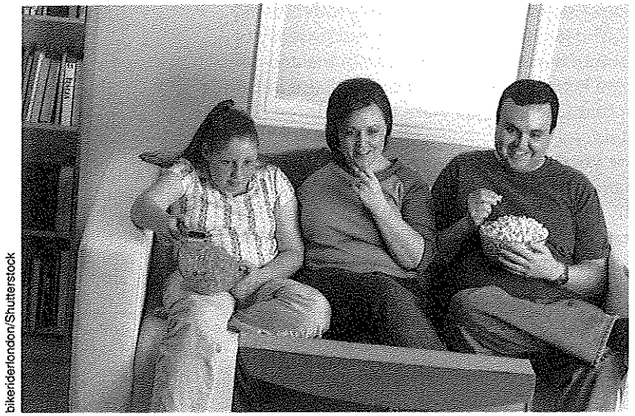
Video Example 6.1

Watch this video on how a lesson on fruits and vegetables could be incorporated into a nutrition unit. In what other ways could you help children learn about healthy foods?

TABLE 6-1 Strategies for Weight Loss

- Increase exercise. Promoting physical activities rather than changing food intake is the most effective way to control a child's weight.
- Limit sedentary activities. Fascination with new media ensures low-level energy use. Encourage children to limit screen time and utilize screen-based fitness activities like Wii Fit.
- Monitor snacks. Use fruit, low-fat yogurt, and fat-free crackers for between-meal snacks.
- Ensure a planned meal schedule.
- Ensure that meals contain good amounts of food from all major food groups.
- Reduce the use of high-fat foods.
- Increase water intake between meals, and reduce or eliminate the use of soft drinks.
- Reduce fast-food use. Fast-food restaurants focus on high-fat foods. Home-cooked meals can provide a far greater balance in nutrition.
- Ensure that adults in the family model good eating habits.

Source: Based on Leach (2010) and Marotz (2015).



bikeriderlondon/Shutterstock

The number of overweight children in America has more than doubled in less than 20 years.

Good nutrition and a focus on preventing obesity will continue to be important topics in school, home, and community. Our culture pays attention to weight issues; hence, many diet programs exist. But people who work with children must exercise care, because children's nutrition is different from that of adults. For example, young children require more fat in their diet for proper energy and for brain development. A general rule for those monitoring a growing child's development is to aim for a steady weight while the child's height increases to correct the height/weight imbalance.

IDEAS FOR YOUR CLASSROOM

Health and Safety

We have discussed several issues that focus on protection of children as they learn. We also have indicated in this section that, although the main responsibility often lies with parents, teachers and community members are involved, too. Consider the following cooperative measures that you as a teacher can try as you plot out a year's activities focusing on health and safety.

1. *Health and safety concepts developed in school or child-care centers can be shared with parents. Most parents welcome additional information and ideas that they can use at home. For example, if your class is studying nutrition, invite parents to attend a session when the children present their representations of a healthy plate, then send the additional nutritional information home for discussion.*
2. *Parents can help present nutrition units at school. Some units will involve food displays and tasting sessions. This highlights the focus on the healthy plate and extends children's experience with new foods. Parents can supply favorite foods or different foods that other children can try. If you are fortunate enough to teach in a diverse neighborhood, the chance of obtaining ethnic foods is much greater.*
3. *When studying nutrition, many schools plan a trip to a working farm, an organic orchard, or a harvesting event. Involving parents in setting up, accompanying, and leading discussions of these experiences is a wonderful way to combine the learning at home with that at school. You are discussing the items that children have on their dinner plates.*
4. *Visits with parents to a fire station are a good way of accentuating the home safety issues that come up during firehouse demonstrations of extinguishers and flammable products common in the home. Have parents make a list of the most dangerous products or have them show escape plans for fires at home to compare with fire drills at school.*

Parents' involvement in these school activities will engender more uniformity in the safety and health information that is promoted in the child's home and school. The discussions will bring out differences that can be analyzed for appropriateness.

PHYSICAL ACTIVITY Provisions for physical activity, exercise, and movement skills are essential in helping children maintain a healthy body and appropriate weight. Many parents readily encourage all types of informal as well as structured games and practice

for their children. This can include everything from encouraging the toddler to take more steps toward urging the primary-school-age child to sign up for Little League. In recent decades, however, educators and medical practitioners have registered concerns about diminishing physical activity in many children's lives. Busy family lifestyles and the amount of time children spend with technology are often blamed.

Video Example 6.2

As you watch this video on the kinds of vigorous physical activity that children need for optimal development, note the social and language development that is also occurring as the children play. What do you think the challenges are in regards to increasing opportunities for physical activity during the school day?

There has also been an erosion of time for children to be physically active in school, as recess and physical education times have been cut to allow more time for academic pursuits. Fortunately, this trend seems to be reversing as more schools recognize the benefits of physical activity on children's school performance supported by research that recommends a minimum of 20 minutes of recess each day (London et al., 2015). Programs such as former First Lady Michelle Obama's "Let's Move" initiative to combat childhood obesity are bringing the importance of regular physical activity to national attention, and organizations such as the American Academy of Pediatrics (2015) provide practical advice on how families and communities can encourage children to be more active. Promoting the use of playgrounds, gyms, and parks and advocating for adequate time for recess and physical education are other areas that have become priorities for families, schools, and communities. The grassroots movement to restore recess is another example of the powerful outcomes that can occur as the three social settings work together.

EXAMINE YOUR BELIEFS AND PRACTICES

Recall scenes in your family life that indicate your family's involvement in helping you learn to make nutritionally wise decisions, be physically active, and get along with others. Have you moved away from these teachings, or do you still retain these habits?

OTHER WELLNESS ISSUES While other features of children's health are addressed elsewhere in the text, two areas merit attention here. Sex education and substance abuse awareness are of particular concern when we are considering how to protect and safeguard children.

FAMILY LIFE EDUCATION Health education is an expected part of a quality child-care and school experience, but education related to sexuality and gender can be a controversial topic. Families have the responsibility for children's sex education, and at the minimum, they should focus initially on attention to biological gender differences, names for body parts including genitals, words for toileting, and knowledge of "good touching" and "bad touching." Families should also help their children understand the social conventions of privacy, nudity, and respect for others in relationships. Additionally, children should learn the very basics of reproduction and an understanding that some people are heterosexual, homosexual, or bisexual. Children should also understand that for some people, their biological gender does not match their gender identity (Key, 2014).

Because sex education outside the home can be controversial, child-care centers and schools must be very clear about their procedures and maintain good communication with the families on the content of their curriculum. Although some programs have a planned curriculum for sexual education, most take a more informal approach. For example, when children ask questions or behave in certain ways, adults provide accurate information and positive guidance. Gender non-conforming children, families led by gay or lesbian parents, and transgender teachers may be part of the school community, and present opportunities for deepening children's understanding of various gender expressions and family configurations. Teachers may also serve as a resource for families and support their role in children's sexual development. Through appropriate sex education, we can ensure that all children, irrespective of their actual or perceived sexual orientation or gender identity, will have a safe and healthy childhood that is free from discrimination (UNICEF, 2014).

SUBSTANCE ABUSE You will find extensive writings and resources relating to the effects of and remedies for substance abuse by youth in America, but with limited space, we will focus on the abuse of one particular class of drugs: inhalants. Inhalant abuse, the intentional inhaling of chemical vapors to achieve a mind-altering effect—much like intoxication—concerns many authorities. The greatest amount of abuse is by children, and the substances used are mostly inexpensive household products, such as cleaning fluids, nail polish remover, butane, hair spray, and a variety of glues. The statistics are startling: Some children as young as age 6 start this abuse, and the greatest amount of abuse is by 10- to 12-year-olds. National Institute on Drug Abuse (2017) surveys find that over 10% of elementary school children have experimented with inhalants, and over 6% fall into the category of abusers.

The problem has social origins, and all too often, it comes from peer group influences. Depression and other mental health issues typically are linked with inhalant abuse when individuals seek euphoric effects as reward or escape. But frequent use of inhalants can be deadly when unconsciousness and suffocation result. Long-term physical effects include brain and nervous system damage, as well as kidney and liver damage.

Recent studies (National Inhalant Prevention Coalition, 2016) show that the problem of inhalant use continues to rise, and the need for more education in the classroom is increasingly apparent. Young children, who have learned about poisons, can also learn that some household substances can be harmful in other ways. Breathing the fumes of cleaning products, solvents, glues, and other products can be dangerous, but proper ventilation and following usage instructions can prevent harm. Teaching children about oxygen's importance to life and how introducing poisons into the body can have a negative impact on body systems and brain function may discourage experimenting with toxic substances.

Because young experimenters have minimal knowledge, they often can be persuaded to experiment with addictive substances that are cheap, available everywhere, and not regulated (unlike nicotine, alcohol, and barbiturates). Children all too often do not connect inhalant use with the harmful effects of scheduled drugs and substances, because the material is found in every family's cupboard or shop. Addictive habits are pleasurable, of course, and the child experimenter feels more confident and the senses "heightened," so it is easy to understand the appeal.

The following symptoms of inhalant abuse can relate to other mild and serious ailments, but if several of them are present, investigation is warranted by parents and child-care workers:

1. Stains on the body or clothing
2. Red and runny eyes
3. Slurred speech, dazed appearance
4. Balance problems
5. Nausea and loss of appetite
6. Anxiety, excitability, or depression
7. Chemical odors on the skin or clothes
8. Sores around the nose or mouth

Careful and dedicated efforts by parents and teachers are required to educate children on the harmful effects of all dangerous substances and on inhalant abuse. All concerned adults, particularly parents and teachers, can develop strategies that will minimize the chances of a child developing a dangerous addiction (National Institute on Drug Abuse, 2017).

The other substance abuse issue that is affecting children is the opioid epidemic. As mentioned in Chapter 1, prescription and illegal opioids killed more than 33,000 people in 2015, and many of those who died were parents (Center for Disease Control and Prevention, 2016). Some children have actually witnessed their parent's death or near death from overdosing, while other children have been accidentally poisoned by their parents' drugs. Children who have parents struggling with their addiction are more likely to be abused and neglected than other children. The mental health issues associated with parental addiction are growing as the opioid crisis continues to expand. As local, state, and federal government agencies struggle to respond to this emergency, teachers should be aware of the signs of distress in children that could be a result of family drug addiction so they can direct children to needed services.

HEALTH SERVICES Children must remain healthy to develop properly, yet access to a health-care system depends on the community in which children live and on the economic status of the family. It is well documented that poor families have greater health problems, including chronic health conditions, more infectious diseases, a higher incidence of low-birth-weight babies, and higher infant mortality rates (Children's Defense Fund, 2012).

To combat these issues, the Affordable Care Act was signed into law in 2010 to reform an inequitable health-care system, focus on prevention of illness, and expand insurance coverage to the uninsured. In 2017, efforts were underway to repeal and replace this law, but it has been challenging for lawmakers to come up with a plan that maintains good coverage for those most in need. Knowing the importance of health for learning, Head Start and Early Head Start programs offer comprehensive health services in the areas of physical, mental, and dental health to the low-income children enrolled.

Head Start also offers education in nutrition and prevention of illness for the families of the children it serves.

Check Your Understanding 6.1
Click here to gauge your understanding of the concepts in this section.

PROTECTING CHILDREN FROM ABUSE AND NEGLECT

Some families provide minimal support for their children's education, either through lack of experience or uncertainty about how to help. Although they provide the basics of primary care—food, shelter, clothing, and safety—parents in impoverished homes may not fully appreciate the notion of educational practice, how learning comes about, or the effects of adult behavior on a child's life. Parent education programs can help families develop environments that nurture children's social and emotional well-being through increased care and interest on the part of the parents. All of this translates into positive self-concepts for children, plus a good foundation for their self-esteem.

In a few instances, parents are so remote and out of touch that the best teachers can do is give constant support, believe in children, and hope that success unfolds in the classroom. Some hard-to-reach parents can be included through persistent communication and emphasis on their strengths and successes with their children. Effective parent education involves increasing parents' level of ability by encouraging them to gradually accept responsibility for their children's overall education. It means trying out different approaches, such as listening to parents' responses, and building on what works.

EXAMINE YOUR BELIEFS AND PRACTICES

Think of young children with whom you have worked and reflect on the needs that their families support well. Also reflect on situations where support seems to be missing. Could you use this information if you were the assigned community worker or the child's teacher?

While some families provide the minimum care for their children and need support to learn how to do more, other families may actively abuse or neglect their children. Many factors contribute to the maltreatment of children, and a full discussion of this complex topic is beyond the scope of this text. It is essential, however, that educators and other community workers understand the types of abuse and neglect, and recognize the signs and symptoms of children who may be mistreated. They must also clearly understand the procedures for reporting their suspicions. Although the Child Abuse Prevention and Treatment Act of 1974 requires all states to establish some mandatory reporting of suspected abuse or neglect, the agencies involved, definitions of abuse, and reporting procedures vary from state to state. You will find that school professionals are obligated to know the regulations in their state.

National child maltreatment statistics for 2015 (National Children's Alliance, 2016) give an indication of the scope of the problem of child abuse and neglect. It is estimated that 683,000 children were maltreated that year. Approximately 75% of these children were neglected, more than 17.2% were physically abused, and slightly less than 10% were sexually abused. Some children were abused in more than one area. In the same year, an estimated 1,670 children died as the result of the maltreatment.

Neglect

Neglect is defined as the failure to provide a child with needed, age-appropriate care, and this inadequate care can be physical, emotional, educational, and/or medical. Despite the large numbers of neglected children, this type of maltreatment has not received the same attention as other areas. But because the lack of adequate nurturance is often readily apparent to others in close contact with the child, teachers and child-care professionals should be vigilant for signs of neglect.

Physical neglect deprives the child of the common necessities of food, shelter, and a safe environment. Physically neglected children are often unwashed, wear dirty clothes unsuitable for the weather, and complain of hunger. They lack appropriate supervision, and can be exposed to unsafe practices and hazards in the home. Emotional neglect denies the child nurturing and affection. Such children may witness domestic violence in the home, abuse drugs and alcohol without parental intervention, and lack needed psychological care. Educationally neglected children may not be sent to school, or may be permitted to miss school regularly. Caregivers do not support the child's educational needs by not obtaining recommended remedial or special education services. Medical neglect is the failure to provide needed health and dental care for the child. Such children may suffer from fatigue, poor weight gain, infected cuts, and other untreated ailments.

Teachers and caregivers should be alert to the following signs and symptoms of neglect, making certain not to label behaviors as neglectful that are the result of poverty, homelessness, or cultural practices:

- Child has poor hygiene, appears dirty, and may have body odor.
- Child wears the same unwashed clothes repeatedly.
- Child's clothing is inadequate or inappropriate for the weather.
- Child complains of hunger and/or rummages for food.
- Child has obvious dental and medical needs that are left untreated.
- Child is chronically late or absent from school.
- Parents/caregivers do not respond to repeated attempts for school conferences or requests to sign papers for needed services.
- Child reports being left alone or with young siblings for extended periods of time.

Physical Abuse

Unlike neglect, which is an act of omission, physical abuse is an act of commission in which children are shaken, beaten, kicked, bitten, burned, or otherwise assaulted. The resulting injuries can range from minor bruises to severe burns or fractures, or even death. Because some parents use corporal punishment as a means of discipline, you will find spanking and paddling are not considered abuse in some areas if it causes no bodily harm.

Children who are physically abused may exhibit some of the following signs and symptoms. Of course, this evidence should be reported:

- Child has bruises, welts, burns, cuts, tears, scrapes, or head injuries.
- Child has repeated unexplained injuries.
- Child complains of pain.
- Child reports harsh treatment.
- Child fears adults or certain adults.
- Child wears clothes to hide injuries.
- Child is frequently late or absent.
- Child has behavior issues such as withdrawal, anxiety, or acting out.

This could be an area where schools can work with communities to establish workshops or arrange speakers to focus on the effects of abuse.

Emotional Abuse

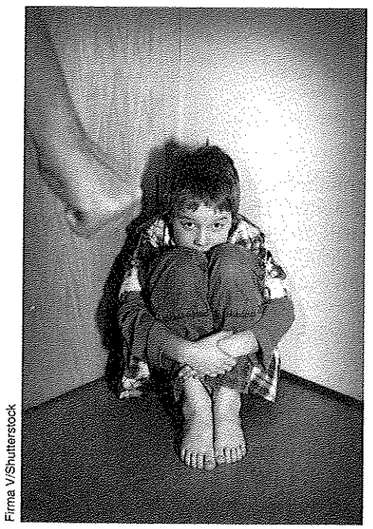
Emotional abuse is characterized by the adult saying things and acting in ways that communicates to the child that he is inadequate, unloved, and worthless. Children who are abused in this way may be ignored, isolated, and prevented from expressing their views and opinions. Alternately, we can find that if they do express ideas, they are ridiculed, silenced, or mocked by peers or other adults. Teachers should look for the following signs that a child is being emotionally abused:

- Child is generally unhappy, and seldom smiles or laughs.
- Child is aggressive and disruptive OR unusually withdrawn.
- Child reacts without emotion to unpleasant situations.
- Child's behavior is either unusually adult-like or childish.
- Child has low self-esteem.
- Parents belittle and denigrate the child.

Child Sexual Abuse

Child sexual abuse is any form of sexual activity (including obscene telephone, text, or e-mail messages) imposed on a child by an adult or another child in a position of power or influence. All of us in the helping professions must work to prevent this. Appropriate sex education in homes and schools can greatly diminish the chances for sexual abuse and exploitation of children.

While most sexual abuse of children is committed by known and trusted adults, teachers, parents, and caregivers must also be aware of predatory adults who sometimes focus on schools. Without causing undue alarm, educators must teach children the basics about being alert to possible dangers, how to move to safe places when they are concerned, and how to report suspicious adult behavior. All states now have websites that identify sex offenders living in a particular area. Although this content represents only a part of the predatory population, it can be an incentive to stimulate parent helpers to monitor the site and outline the defensive behaviors that young children need to know.



Firma V/Shutterstock

Fear, withdrawal, and inability to concentrate are some of the symptoms of child sexual abuse.

Perhaps the best way to prevent sexual abuse is for parents and other adults who have contact to communicate steadily and often with their children. But parents as well as other adults working with children should recognize the basic cues that signal abuse, and be knowledgeable about ways to respond to abuse—including reporting it to authorities. Concerned adults should know the following information about the typical child victim:

- The victim may be a boy or a girl from any socioeconomic background.
- In most cases, the victim knows and trusts the abuser.
- The victim may be an infant, toddler, preschooler, or school-age child.
- The victim is usually reluctant to report the abuse for fear of punishment.
- The victim is rarely abused by a stranger.

As we noted earlier, healthy education about our bodies provides a good base for discussion and education about abuse. Children must know that their bodies belong to them, and if someone wants to touch them in places that are not acceptable, they should refuse, leave, and tell someone. The best procedure for parents and child-care workers is to assure children that they will not be blamed for any abuse they sustain. Adults should take care not to frighten children when abuse is suspected, but rather to show support for the child. Also, children may be too frightened to talk about sexual molestation, but they may exhibit behavioral signs that suggest abuse. Adults should be alert to symptoms, including:

- Changes in behavior, such as loss of appetite
- Fear of the dark or sleep disturbances
- Regression to more infantile behavior such as thumb sucking
- Excessive crying
- Expressing affection in ways inappropriate for a child of that age
- Interest in or precocious knowledge of sexual matters
- Fear or intense dislike of a particular person
- Fear of being left alone or in a particular place
- Change in school patterns—reduced attendance, excessive daydreaming, or inability to concentrate
- Aggressive or disruptive behavior, withdrawal, or delinquent behavior

As in other diagnoses, the symptoms for neglect, physical, emotional, and sexual abuse can be related to other difficulties in a child's life.

> ✓ **Check Your Understanding 6.2**
> Click here to gauge your understanding of the concepts in this section.

SAFEGUARDING CHILDREN FROM VIOLENCE AND BULLYING

Children who witness domestic violence in their home or are the victims of bullying may display many of the same symptoms as an abused or neglected child. It can be challenging to uncover the source of a child's distress and even more difficult to determine how to help. You may need to turn to your school counselor or social worker and ask for their support when you suspect a child is in need of protection.

Domestic Violence

Like child abuse, domestic violence can be physical, sexual, emotional, or psychological, but these behaviors occur between the adults in a household. These abusive actions are used by one partner to gain or maintain power or control over another through fear, humiliation, isolation, and threats. Domestic violence occurs in all socioeconomic groups, and can happen to people of any race, age, sexual orientation, religion, and gender. Studies indicate that there is an overlap of between 30% and 60% between domestic violence and child abuse (National Coalition Against Domestic Violence, 2017). Therefore, some children may be victims of child abuse and witnesses to domestic violence as well. Children who are not being abused but are being raised in situations where domestic violence occurs are still at great risk.

Exposure to violence in the home can lead to numerous physical, social, and psychological problems for children. Such children tend to be more aggressive and fearful, and may suffer from anxiety, depression, and stress-related ailments like headaches and rashes. In adulthood, children who have witnessed domestic violence have higher incidences of tobacco use, substance abuse, cancer, heart disease, and depression (Futures Without Violence, 2017).

The outcomes for children exposed to violence can be improved, however, through therapy, parent education about the devastating effects of violence on children, and the development of safe, stable, and nurturing relationships with caring adults. Once again, partnerships between the school, home, and community can be used to support children and provide them with needed services. Alert teachers working with school personnel can be a vital link in helping children in these circumstances.

Confronting Bias and Prejudice

Our society still struggles to shed the problems associated with racism, ethnocentrism, sexism, homophobia, religious intolerance, and discrimination against certain disabilities. Research by the Southern Poverty Law Center (2017) has identified 917 active **hate groups** operating in the United States today. These groups have beliefs or practices that attack or malign an entire group of people, typically for characteristics such as their race, religion, or sexual orientation. Regrettably, **hate crimes**, particularly against Muslims, spiked after the 2016 presidential election, but such crimes have been prevalent for many years. Schools are not immune to these incidents of prejudice, although actual hate crimes are rare in that setting. When bias and demeaning language and actions surface, the targeted persons are affronted, their aspirations suffer, and all children's growth in social competence is diminished (Derman-Sparks & Edwards, 2010). For all persons involved, bias is costly.

As an educator, you have a responsibility to confront bias and help young children move beyond it. Using multicultural materials in as many school projects as possible is a good start; use and involve your parent group in presenting these materials. Planning regular units on diverse cultures and observing a variety of ethnic and religious holidays will help build children's understanding and appreciation of various groups. The book *Anti-Bias Education for Young Children and Ourselves* by Louise Derman-Sparks and Julie Olsen Edwards (2010) and the Southern Poverty Law Center's Teaching Tolerance materials contain excellent sources for strategies addressing this topic.

EXAMINE YOUR BELIEFS AND PRACTICES

What memories do you have about what your family and school taught you about various kinds of diversity among people? What childhood experiences did you have with people who were different from you in race, culture, family structure, economic class, religion, or sexual orientation? Reflect on how you felt about these experiences. Do you agree or disagree with your parents' views about groups different from your family? If you disagree, how did you develop your own ideas? How will you use your own experiences to help the children you teach embrace and appreciate the diversity among their peers?

Protecting Children from Bullying

In concert with expanded violence and aggression in the media, American schools and neighborhoods are experiencing negative social behaviors such as hazing and bullying. **Bullying** is unprovoked verbal or physical aggression toward others, and is traced to aggressive behaviors in homes and in media, attachment problems, child abuse, and even genetic inheritance (Espelage & Swearer, 2011). Often linked with males in previous generations, bullying has also become common among girls (Anthony & Lindert, 2010). Families as well as schools and communities are justly concerned about the increase in bullying, and plans are needed to modify this dangerous behavior. Socialization processes for youth need ongoing evaluation, and all families need to work with their

schools to develop skills in anticipating **harassment** and bullying acts. Then they must use strategies to teach negotiation, compromise, and **conflict resolution**.

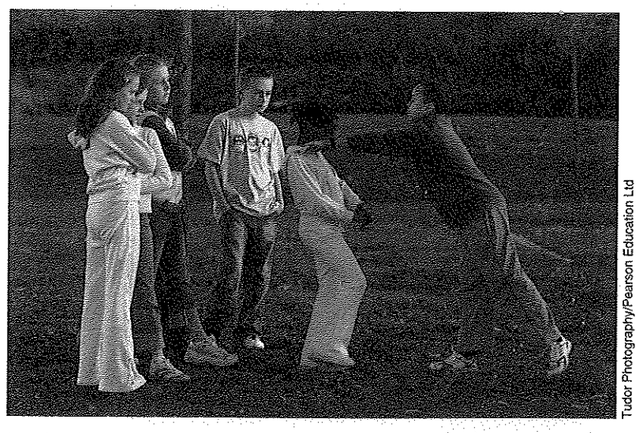
Bullying behavior appears to be increasing in US schools and neighborhoods, and this had led to serious study of its occurrences and implications. This cruel behavior used to be dismissed as "playground squabbling" or normal growing-up dander, but recent research shows long-term harmful effects on victims as well as perpetrators (Bazelon, 2013). The following vignette presents an episode from the 1950s that could just as easily occur today.

A group of third graders is gathered at the corner of the schoolyard at recess time. Jamie, a robust and popular child, is surrounded by a group of friends, and all are joking and "horsing around." Ralphie, a small child with learning disabilities, stands on the sidelines, watching the others play jump rope.

"Hey, Ralphie, want some gum? Look, I got some gum you can have." Jamie holds up a stick of gum toward Ralphie while pushing a wad of gum around in his mouth. Suddenly, Ralphie and Jamie have the attention of all the children in the yard. Ralphie looks anxiously at Jamie for a moment, but then begins to move forward. "Come on, Ralphie, you can have some, but you gotta come and get it! Right here! Come on! Come on!" Jamie points to a spot just in front of him. Ralphie again moves forward as Jamie urges him to come closer and closer until both boys are almost nose to nose. Then Jamie suddenly pulls the wad of gum from his mouth and sticks it on Ralphie's nose. Most of the children on the playground burst out laughing as Ralphie runs back to his corner.

According to information collected by the Congressional Research Service (2013), 50% of schoolchildren are bullied at some point in their lives, and at least one-half of those children are victimized on a regular basis. This adds up to a huge number of children who, like Ralphie in the vignette, lead anxious and hurtful lives every day. Bullying can occur anywhere, but most frequently it happens on school buses, on playgrounds, in school restrooms, in stairwells, and during after-school activities. Schools and communities have the resources to combat this behavior if responsible adults observe, investigate, and plan solutions. Changes do take time, because interveners will need to reorient life patterns and habits of young people.

DEFINING BULLYING Bullying is present when a more powerful person hurts, frightens, or intimidates a weaker person on a continual and deliberate basis. Bullying can be verbal, physical, or indirect. Verbal bullying may include name calling that arises from a person's gender, sexual orientation, minority status, race, religion, or other characteristic that sets them apart. Physical bullying includes some sort of attack or assault and the destruction or theft of the victim's property. Indirect bullying involves spreading stories and rumors about a person and exclusion from social groups.



Tudor Photography/Pearson Education Ltd

In-school bullying has long-term effects on perpetrators as well as victims.

Video Example 6.3

Watch this video of a young girl explaining how she feels about being the target of indirect bullying. Cyberbullying is another form of indirect bullying, which will be covered in the section on media protections. How do you think you could get peer involvement to start addressing bullying behavior in your classroom?

A bully's actions are the unprovoked and repeated aggressive actions that cause fear, distress, or harm to a victim. Bullying is not retaliatory anger; it is about contempt for someone considered inferior, as the vignette demonstrates. Additionally, bullying often occurs in the presence of bystanders who can stimulate or encourage the assault or dampen the aggression when someone takes a stand against it. Figure 6-3 outlines the types of bullying.

Bullies come in all sizes and shapes: small or large, male or female, attractive or unattractive, popular or isolated, skillful or clumsy. Their common quality is that they all take pleasure in putting down and harassing their self-defined victims. Environmental factors such as limited friendships, abusive homes, negative role models, or attachment problems can contribute to bullying behaviors, and violent media effects seem to enhance these behaviors. Bullying is violence, and the behaviors often lead to more violence as the bully matures. Thus, intervention and redirection should be the goals of schools and communities when this problem comes to light.

VICTIMS AND BYSTANDERS Like bullies, the victims of bullying are a diverse group, but are frequently quieter or less assertive children. Those who are overweight, have a disability or have a minority background are more often targeted. The social skills of victims can be lacking, and they may be easily upset or anxious about schoolwork or schedules. Of course, bullying extends the difficulties of a targeted child, and may even bring about negative health effects such as headaches, stomach aches (Gini & Pozzoli, 2013), or even mental health issues. Bullied children reported that the most helpful things teachers can do are listen, check in with them afterwards to see if the bullying stopped, and give them advice. On the other hand, the most harmful advice teachers can give are to tell the student to stop tattling, solve the problem themselves, or say that the bullying wouldn't happen if they acted differently or ignored what was going on. Actions aimed at changing the behavior of the bullying youth (fighting, getting back at them, telling them to stop) were rated as more likely to make things worse (Davis & Nixon, 2010).

Bystanders are those who observe and at times participate in bullying. Rigby (2008) notes that bystanders are always for or against the victim, but they rarely take up the victim's

FIGURE 6-3 Types of Bullying

Physical Bullying
- Hitting, kicking, shoving, tripping
- Ruining or hiding someone's possessions
- Badgering or forcing a victim to do something he or she does not like or want to do

Verbal Bullying
- Teasing, taunting, or goading
- Insulting, making deriding remarks, or asking demeaning questions
- Expressing ethnic or racist slurs

Social or Relational Bullying
- Persuading others to exclude someone
- Manufacturing rumors or telling lies about someone
- Refusing to talk to or socialize with someone
- Coercing someone to do things he or she does not want to do

Cyberbullying
- Using information and communication technologies to harm someone known or unknown
- Intimidating, controlling, putting down, and humiliating someone through text, e-mail, social media, etc.

cause. Yet, students who experience bullying report that allying and supportive actions from their peers (such as spending time with the student, talking to him/her, helping him/her get away, or giving advice) were the most helpful actions from bystanders (Davis & Nixon, 2010). Bystanders' beliefs in their social self-efficacy were positively associated with defending behavior and negatively associated with passive behavior. In other words, if bystanders believe they can make a difference, they're more likely to act (Thornberg et al., 2012).

Responsible educators and child-care professionals must root out bullying behavior and work to redirect the lives of all concerned. Since students who experience bullying are more likely to find peer actions helpful than educator or self actions (Davis & Nixon, 2010), working with the bystanders is a good first step. Because of their sideline status, they can look more objectively at the problem and the reasons for it. And their participation will be valuable as a new regimen is instituted. Of course, all responsible adults should intervene when there is an obvious victim. Careful work needs to be done, however, to defuse the behavior and work toward a safer and happier school community.

IDEAS FOR YOUR CLASSROOM

Investigating a Bullying Problem

One way to start solving a bullying problem is to enlist the help of parents, other educators, and community helpers. Start with carefully selected parents, school specialists, or clergy members to interview children about the situations at their school. Questions could be as follows:

- *Are you ever teased at school?*

- *Do you know if others are teased?*
- *How do you feel when you see others hurt or frustrated by teasing?*
- *Do you tell your teacher or anyone else about the teasing?*

The information gathered can be the basis of an intervention program. One approach could be to start a chapter of the Ambassadors for Kids (A4K) Club. This group supports the idea that children can make a positive change in their schools, neighborhoods, places of worship, and homes by speaking out against abuse and harassment toward themselves, their siblings, friends, and other youth. The objective of A4K is to educate children on the forms of abuse, including bullying, and encourage and empower them to speak out to help stop or even prevent bullying from occurring. The organization provides information and resources to parents, teachers, and children.

Protecting Children from Dangerous Adults

One of the greatest terrors for parents is abduction by strangers. While this is far less probable than molestation by neighbors, acquaintances, and family members, children must still learn how to avoid dangerous situations and report suspicious behavior. They must also learn the importance of never going with a stranger. Many families have developed a code word for the child to ask for if someone claims to be connected to their family and instructed to take the child somewhere. Parents, teachers, and caregivers should teach children not to keep any secrets when an adult has done anything to their bodies. This will take ongoing education to help children learn how to be safe.

Community violence is hard for children to understand and accept, but violence that spills over into schools is especially frightening. In addition, although some schools are considered safe havens from distressful conditions in a neighborhood, too often these protected spaces are savaged by intrusions, bullets, and intimidation by gangs. But as the 2012 shooting deaths of 20 children and six educators at Sandy Hook Elementary in Newton, Conn.—a middle class, suburban community—showed, no school is immune from the threat of gun violence.

Schools in most communities now have locked doors, a single point of entry, and other enhanced security safeguards. Lockdown drills are conducted to prepare children and staff for the possibility of an armed intruder. Debates now rage over the possibility of armed guards and armed teachers at elementary schools versus the need for stricter gun control laws.

Talk about violent acts and the use of weapons has an unsettling effect on the school climate, of course. In the hands of secure teachers, however, the trauma resulting from witnessing violence can become part of the school curriculum. One teacher who was trying to resolve fears in a Baltimore neighborhood that was experiencing periodic violence used story writing and sharing to deal with children's anxieties and to help the children understand precautions and safety measures.

Check Your Understanding 6.3
Click here to gauge your understanding of the concepts in this section.

ENSURING MEDIA SAFETY

The entertainment industry is part of the greater community, and is probably the most pervasive force in children's lives today (Strasburger, Wilson, & Jordan, 2014). From earliest times, societies have recognized a need for activities that lift spirits and entertain, so we should expect that a thriving community will encourage and support entertainment for its citizens.

Communities have planned occasions and established recreational facilities that provide for entertainment—sports areas, natural areas, and parks. Parades, community fairs, and other celebrations also are typical. But in addition to the public settings, private industries have been established in most communities for the purpose of delivering entertainment. Theaters, cinemas, malls, coffeehouses, arcades, and theme parks are some of these entertainment venues.

With the explosion and transmission of knowledge in the information age, children have become engulfed by entertainment media on command, day or night, right in their own homes. The following are typical formats that children and young people possess or have ready access to from family members:

- Desktop, laptop, and tablet computers, smartphones, handheld games, gaming system
- Movies and television shows that can be streamed onto most of the aforementioned devices
- Apps and games that can be played/viewed on various devices
- Local and satellite radio
- Internet linkages to social networking sites, photo sharing sites, and innumerable other websites

Whether in an isolated prairie town or an urban neighborhood, the impact of the media is now all-encompassing in children's lives. While no one doubts the benefits of computers and digital technology, the risks of media addiction, distraction, lack of privacy, and possible loss of innocence are growing concerns. What the long-term impact of media exposure on children will be is unknown at this time. However, many adults, including parents, educators, and other professionals, have raised issues about media use and children.

Concerns about media safety center on the amount of time children spend engaged with technology and the quality and appropriateness of the materials to which they are exposed. One challenge facing parents and schools is that media entertainment may be overutilized in relation to other activities and pursuits. Other challenges include protecting children from inappropriate content, cyberbullying, and commercialism.

Time Spent on Media Entertainment

The time allotted to media use can intrude on families' and children's schedules, creativity, schoolwork, play, and socializing (Carlsson-Paige, 2012). Overuse is also a factor in the obesity epidemic, as children spend less time being physically active when they are engaged with media. Excessive screen time is also linked to poor school performance, sleep and eating disorders, and attention problems. While the responsibility for establishing limits on usage rests primarily with families and primary caregivers, community and school support also can assist in managing this.

The American Academy of Pediatrics (2017) defines screen time as time spent using digital media for entertainment purposes. Other uses of media, such as online homework, don't count as screen time. The academy recommends that for children ages 2 to 5, screen time should be limited to one hour per day. For ages 6 and older, parents can determine restrictions on viewing time, as well as monitor the types of digital media their children use. Infants ages 18 months and younger should not be exposed to any digital media; breast- and bottle-feeding are crucial bonding times, and face-to-face interaction, especially eye contact, is crucial for optimal brain development. If parents' attention is on a TV or phone screen, babies are deprived of that attention, and if they are repeatedly neglected in favor of digital media, children may develop behavioral issues in the future.

We find that the amount of time children actually spend with screen media is well beyond those guidelines—fifty-three hours a week for children ages 8 to 18 (Kaiser Family

Foundation, 2010), and about seven hours a day for children overall (American Academy of Pediatrics, 2017). For many children, these hours include media multitasking—using more than one device simultaneously. Many babies and toddlers are surrounded by technology throughout the day despite their rapidly developing brains, which learn best through interacting with people.

The time children spend with screens is time they are not spending reading, playing actively and imaginatively, and engaging in hobbies. Nelson (2012) cites this preoccupation with electronic media as one of the seven critical issues children face today, along with lack of exercise and lack of engagement and connection to the world, including nature. Many families enforce screen-free meals or observe a digital holiday once a week, a 24-hour period during which everyone puts away all of their devices. Instead of using technology, families do things that may have disappeared from their lives, such as playing games together, spending time outdoors, or reading. Some schools, communities, and organizations have successfully run programs in which children and their parents turn off screens during a designated week in the spring. What began as TV Turnoff Week some years ago has evolved into Screen-Free Week sponsored by the Campaign for a Commercial Free Childhood. This group's website provides an array of information and resources to help people organize local campaigns that encourage people to refrain from using screens for entertainment for a week, substituting other exciting activities. At the end of the week, sessions are planned to help the participants discuss the experience. See the Resources section at the end of this chapter for further information.

The day-to-day reality, however, is that children spend an enormous amount of time plugged into various media outlets. For example, the speed with which social networking has become a potent force in their children's lives has felt overwhelming for many parents and educators, and many feel unprepared and powerless in dealing with it (Steyer, 2012). Social media sites have changed the way children and young people communicate, establish and maintain relationships, and develop and define their own identities. For many children, participating in such sites has stripped away their privacy before they even have a concept of what privacy means. Posting on social networks, texting, and other forms of online communication have also increased the amount of bullying, gossip, and exclusion that can be so devastating to children.

Cyberbullying

As increasingly younger children obtain smartphones and begin to participate in various online social networks, cyberbullying, once confined to teenagers, has emerged during the elementary school years as well (WiredSafety, 2017). Cyberbullying can take many forms, including the following:

- Texting, posting, or e-mailing mean or hurtful messages or threats to an individual
- Texting, posting, or e-mailing rumors about an individual to others
- Stealing an individual's account information and sending damaging messages under his or her name
- Pretending to be someone else online to hurt an individual
- Circulating sexually suggestive pictures or messages about an individual (sexting)

While some cyberbullies think these behaviors are funny or that they are just joking around, the effects on victims can be severe. Anxiety, depression, and even suicide have resulted from cyberbullying. In the adolescent population, over half report being bullied online, and the same number have reported engaging in cyberbullying. Research has shown that parents and teachers who explicitly express to children that bullying behaviors are wrong and impose penalties for those caught engaging in it can reduce the amount of cyberbullying (Patchin & Hinduja, 2016). However, most children do not tell their parents or other adults when cyberbullying occurs.

IDEAS FOR YOUR CLASSROOM

Partnering with parents to confront cyberbullying

Even if an incident of cyberbullying has not yet occurred in your classroom, you may want to be proactive and plan a workshop for families to communicate with them about this new form of bullying. The main message to convey is that teachers and parents need to talk with children about cyberbullying at home and at school. The following suggestions include ways to prevent and cope with cyberbullying:

- *Make sure children understand that cyberbullying isn't funny, and can have serious consequences for all involved*
- *Use stories and case studies as discussion starters to help children learn what to do if they find out someone is bullying or being bullied online*
- *Encourage children to tell an adult if they are being bullied*
- *Save all cyberbullying messages as proof that it is occurring*
- *Parents may need to contact the bully's parents, internet or cell phone provider, or the police*
- *Block the person sending messages*
- *Practice common-sense media use at home*
- *Keep the computer the child uses in a shared family space*
- *No sharing of passwords outside the family*
- *Prevent internet use in children's bedrooms*

Entertainment Media Content

Because most media are protected under First Amendment provisions, media outlets are largely self-policing, and public acceptance of the products determines the boundaries for individual distributors. Appropriateness of media content is a significant issue when we consider children's education. Many programs, games, and recordings are adult-oriented in topic, format, and relevance; nonetheless, children are exposed to large quantities of them. But criticizing media products that fall outside a community's standard invites thoughts of censorship, and problems always surface when that issue is raised. Therefore, it is desirable for communities to reach a consensus on acceptable quality through public forums, then work for that standard through educational programs and lobbying efforts when required. TRUCE (Teachers Resisting Unhealthy Children's Entertainment) is a grassroots organization of educators who prepare materials and provide information to help parents and educators counteract the harmful impact of commercial culture, media, and marketing on children's play, learning, and behavior.

Communities have a legal responsibility to protect children from inappropriate situations. However, parents have the ultimate obligation to ensure their children are not exposed to content they consider unsuitable or dangerous. Technology, including filters for internet surfing and protection devices to block certain TV programs, has been developed to help parents control what comes

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Appropriate use of media is an ongoing educational objective for children.

into and out of the home. Some devices can even control the time when the television is on and off. The V-chip for television and parental control software such as Net Nanny and CYBERsitter are designed to protect children from pornography, online predators, cyberbullying, and other dangers, but in reality, they probably block only a fraction of inappropriate material. One of the best protections for children is having parents who engage in media use together, talk to them about media, and establish guidelines for its use.

EXAMINE YOUR BELIEFS AND PRACTICES

As a child, you most likely were enticed by some clothing products or breakfast cereal advertised on a Saturday-morning TV program. This may have led to campaigns to convince your family to buy particular items for you. Check out a current TV program directed to 8- to 10-year-olds to see the type of products featured and the persuasive patterns of presentation. How do these advertisements compare to those you remember from your younger years? Do you feel that the current marketing approaches exploit young children?

Marketing to Children

During the 10,000 to 15,000 hours of television the average child watches by the age of 18, over 200,000 commercials also will be viewed. Through television and portable screen technologies, marketers now have direct access to children's attention, and this has led to concerns about the increasingly commercialized culture of childhood in the United States. Many parents, educators, and concerned citizens have observed that these products marketed to children seem to be factors in the rise of childhood obesity, eating disorders, violence, early sexualization, materialism, and the demise of creative play. Children often take advertisements at face value, and are not at a developmental level to understand that ads may be misleading and untrue.

The Campaign for a Commercial Free Childhood, the initiator of Screen-Free Week, is a national group working to end the practice of child-targeted marketing. Their goal is to build public awareness about the harm of marketing to children (Carlsson-Paige, 2012), and they hold regular summits for researchers, parents, educators, health professionals, and others to collaborate on ways to combat exploitative advertising to children.

Check Your Understanding 6.4

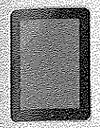
Click here to gauge your understanding of the concepts in this section.

COMMUNITIES, SCHOOLS, AND FAMILIES WORKING TOGETHER TO PROTECT CHILDREN

All communities have established schools within their boundaries to develop children's cognitive and affective skills. In recent years, however, increasingly heavy burdens have been placed on schools to assume even more responsibility. In addition to expected academic activities, many schools provide two meals per day and pair with nonprofit (or for-profit) organizations for before- and after-school care, tutoring, and recreation. Schools are assuming a larger part of the parenting role, and this requires good communication, more understanding, and cooperation from families if the overload taking place in some schools is to be successfully managed.

Schools also need widespread community support to fulfill their increased responsibilities. A groundswell of support for promoting education and safeguarding children does not just happen, however; such support indicates that committees, groups, and leaders have been active in establishing goals and lobbying for better conditions. And we find that the electorate and community decision makers are almost always motivated to strive hard to support more educational opportunities—particularly for young children.

MEDIA MATTERS



Online communities are becoming an increasingly important way for families to find guidance and support. One example is the My Plate, My Wins initiative from the US Department of Agriculture. Besides the Choose My Plate website based on the current Dietary Guidelines for Americans, individuals can connect to nutrition content and others with a shared interest in healthy eating through MyPlate social media platforms such as Facebook, Pinterest, and Twitter. The MyPlate Facebook page offers tips, resources, materials, recipes, and a food tracker. MyPlate Recipes on Pinterest focuses on healthy recipe sharing, and @MyPlate on Twitter offers daily tweets on food, recipes, and active lifestyles. Social media has the power to reach broad audiences, and will play an important role in protecting and safeguarding children.

Regrettably, some communities do not facilitate and nurture children's education or ensure their safety and well-being. The community context affects and controls family and school settings to a large extent, and when economic, social, and political crises arise, community problems always detract from school programs and other educational objectives. Controversy often minimizes nurturing, and too often, it prevents the community from making changes that have been initiated in schools and the community at large. Extensive social remediation is needed in some locations to increase their effectiveness.

Community Effectiveness

It is difficult to determine cause-and-effect relationships within a community, especially those that affect children. But many factors, such as these listed below, are closely related to community effectiveness, and contribute to the ways a community supports school and family efforts to protect and safeguard children.

RELIGIOUS INSTITUTIONS Churches, synagogues, and mosques are central facets of many US communities. In fact, we find that different religious establishments represented the largest part of out-of-home activity for pre-20th-century Americans. While national surveys reveal a drop in religious participation in recent years (Pew Research Center, 2015), more individuals belong to religious groups than to any other voluntary groups. Religious institutions continue to influence many segments of US communities, promoting cultural and ethnic as well as theological identity.

Together with outreach programs and social action objectives, many places of worship now provide various kinds of support for their communities as well as spiritual nurturance for their members. Food pantries, soup kitchens, shelters for homeless or abused persons, and drug abuse and family counseling services all are operated by or through religious organizations in thousands of communities. Many child-care programs are not-for-profit arrangements developed and maintained by local religious organizations, even in the smallest communities. While **faith-based** group funding for community welfare can be controversial in political as well as educational circles, many religious groups provide important protective services for children and families.

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Some volunteer groups are very helpful in promoting school programs, while others thwart well-reasoned objectives.

CIVIC SERVICES All communities require fire departments, sanitation programs, and public safety offices. Supported by tax revenues, these services provide for the general stability and safety of the community.

Community services provide an educational function for children, and can help them learn health and safety precautions. What goes on in those departments, how the jobs are done, and the problems workers encounter interest all children. Most offices publish materials and have personnel who head information programs for schools and other local groups. When directed by their teachers, elementary school children learn to understand the meaning of organized communities and the interdependence of community residents. They learn how community services affect their lives and protect and safeguard them and their families.

BUSINESSES Most communities include private commercial enterprises linked to daily life in those areas. There will be grocery stores, gas stations, and convenience stores found in nonindustrialized suburbs. Other communities contain factories, wharves and piers, and large merchandise outlets, plus financial and information-processing establishments that employ residents and give flavor to a community.

In effective communities, commercial establishments cooperate with schools and families. Such cooperation demonstrates commitment to the interdependence of community settings and the need for mutual support.

SPECIAL-INTEREST GROUPS Special-interest groups are grassroots associations that are very American in concept. Taking as their basis the constitutional amendment protecting association and assembly, citizens come together to work for or against a cause. In this way, altruistic groups have formed to gain privileges for disenfranchised persons (e.g., achieving passage of an education bill for persons with disabilities in the 1970s) or to highlight a public problem (such as stopping gun violence). Other groups form to oppose regulations or practices. For example, the group Defending the Early Years (DEY) seeks to rally educators to take action on policies that impact the education of young children. Its principal goals are to mobilize the early childhood community to speak out with well-reasoned arguments against inappropriate standards, assessments, and classroom practices; promote appropriate practices in early childhood classrooms; and support educators in counteracting reforms that undermine these appropriate practices. Many groups disappear after accomplishing their mission; others become entrenched because their cause is ongoing.

Volunteer groups often come together to be advocates and sources of support for schools. For example, a group formed to lobby for school building improvements can have a positive impact. However, some lobbying groups are formed to counteract educational projects or prevent curricula from being implemented, as shown in the following vignette.

A group of parents and two clergymen in a Texas community organized themselves as a self-appointed school review committee. When they reviewed the reproduction-of-creatures unit for the second-grade classes, the books and charts used became a highly charged topic. The group's complaints about the material became intense, and the committee's visits to the school caused confrontations and wild charges. One teacher resigned because of accusations, and negative publicity dragged on for weeks before the administration chose to abandon the unit. Even though the unit had been developed in previous years and had been accepted by the health education committee, a militant anti-sex-education group spread dissension and won their case in this community. Community–school working relations were set back considerably for several years.

Censorship of books is still a common occurrence in school districts throughout the United States. Too often, schools acquiesce to pressure from lobbying groups to abandon certain publications and other resources. When this happens, the scope and purpose of programs can suffer. All challenges are handled more effectively when schools have well-planned school objectives and an educational process that involves homes and communities in explaining the curriculum.

Here is where you can bring the power of your home and community partners to bear on a particular challenge. Anticipate pressure-group action by developing an advisory committee of parents and representatives from your local churches and social groups. Prepare the group well by explaining the content of your projects and units. Invite them to help select materials. Talk about controversial topics and how to inform the committee about new literature or exhibits. Then, if a challenge comes, you have a team working with you to interpret and help inform people who do not accept some features of your projects and units.

Social Systems and Community Support

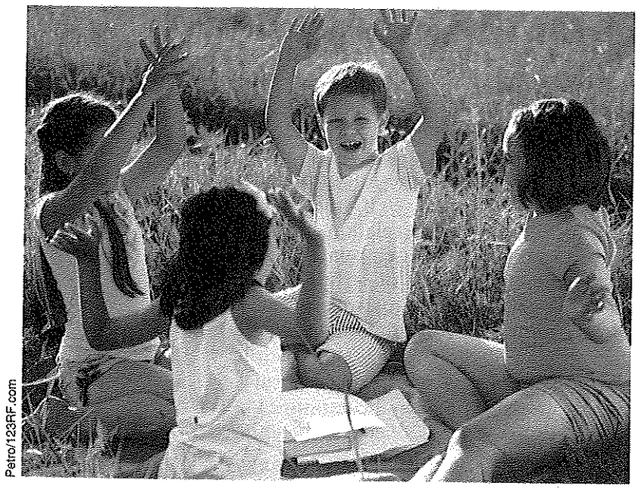
The informal, everyday contacts of relatives, neighbors, friends, and colleagues produce social systems for adults and children in almost all neighborhoods. These groupings, which can cross gender, age, and socioeconomic lines, provide enormous support for individuals. For example, Werner (1999) showed in the book *Through the Eyes of Innocents* the strong impact of healthy behavior in a community on children caught up in war.

POSITIVE ADULT GROUPS Social science research shows the importance of friends and relatives in providing psychological support for children (Center on the Developing Child at Harvard University, 2015). All children need a relationship with at least one stable, caring, and supportive adult in their lives. Such relationships begin in the family, but they can also include neighbors, providers of early care and education, teachers, social workers, or coaches. These support groups are especially important for at-risk families. When kin and colleagues provide emotional support for child rearing or confronting adversity, the entire family benefits. Healthier adult groups mean healthier environments for children. You can appreciate that information about social services, work opportunities, or new resources in a community is often delivered through the social connections of adults, and this, of course, benefits children.

While some skills and attitudes are best enhanced through projects and activities under community sponsorship, individual efforts also can be important. We as educators must be alert for opportunities for collaboration between individuals, community agencies, and schools that promote children's education and welfare. The following vignette illustrates this point:

Life in the small coastal community was quiet, and Josh and his friends were restless after a month of summer vacation. Returning from the ball field one day, they pedaled their bikes toward home, throwing rubbish from their lunches at poles and fences. They seemed intent on spoiling their community's quiet roadside beauty. At one lovely spot near the ocean, however, they noticed a painter setting up his easel, and stopped to watch. The painter paused, then asked the boys if they would help him clean up debris near the shoreline so that he could paint without distractions. The boys did, then stayed to watch the man work. The boys became fascinated with the artist's rendering, and the painter became aware of how little experience these youngsters had in developing a sense of their surroundings.

A few days later, the artist and a colleague invited Josh, his friends, and their parents to their studio to talk about their art and its relationship to the world around them. This worked so well that the artists, with the help of a small group of parents, persuaded town officials to budget space and funds to open a modest gallery in the community. Classes in painting and art appreciation now are offered in the gallery, and the artists are helping teachers at the local elementary school integrate art into their curriculum.



Petro/123RF.com

Peer groups provide early experience in social interaction and cooperation.

No single agency—home, school, or community—felt a need or responsibility for developing the aesthetic senses of Josh and his friends, but an interested citizen was able to establish a link with this responsibility and provide a needed aspect of curriculum for the youth in that community.

CHILDREN'S PEER GROUPS Peer groups exert a strong influence in any community. **Peer groups** are social in nature, and by their actions, they provide experiences for those involved. Constructively, peer groups provide children's all-important coming-of-age experiences, where children encounter folklore and rituals, experience a sense of belonging, and begin to develop competitive skills (Howes, 2009). Peer groups also provide early experience in social interaction and cooperation. Destructively, peer groups may evolve into alienated gangs that commit acts of violence and hostility.

Victoria and her mother walked next door to welcome to their southern California community the new family that had just arrived from Hawaii. The two new girls, Terry and Adrianne, came the next day to Victoria's yard to play. They taught Victoria a new version of hopscotch. But while the girls were playing, the neighborhood gang appeared and told Terry and Adrianne that they had to leave, because "We don't play with Chinese kids." Victoria's mother, witnessing the scene, hurried out to the yard and asked the new neighbors to stay. "All children are welcome in this yard as long as you play well together. Now, I saw the fun you two had showing Victoria that new hopscotch. Perhaps you'll teach these other children how to play it, too?" The mother tended her shrubs and observed for a while, but as all the children got involved in play, she left them to negotiate on their own.

Victoria's mother warded off hostility toward the new children in the neighborhood by suggesting and guiding a constructive experience. Teachers in schools and family members both have a responsibility to monitor and at times guide children's peer interactions when conflict seems imminent.

IDEAS FOR YOUR CLASSROOM

Safeguards

The following are some questions that you can use when checking out how your school ensures the safety and well-being of its students. The answers will reveal much about your school's commitment to protect and safeguard children.

- *Are indoor facilities safe, clean, and free of hazards?*
- *Are outdoor play areas well-maintained and inspected regularly for safety?*
- *Does the cafeteria serve nutritious and appealing meals?*
- *Do the children have adequate time and space for active play during recess?*
- *Do teachers know the procedures for reporting suspected abuse or neglect of a child?*
- *Are there clear policies for responding to discrimination and bullying, and are they followed?*
- *What security measures are in place to protect children from intruders?*
- *Are collaborations on the above between home, school, and community evident?*

By expanding and building on the protective strategies started in the home, partnerships between school and home assure protection for children and continuity of their learning. Whenever one enhances the objectives of the other, the result is an enriched experience for children.

Check Your Understanding 6.5

Click here to gauge your understanding of the concepts in this section.

Summary and Review

The three social settings have a shared responsibility for making certain that optimal conditions and arrangements are in place for protecting children. Tradition and law impose requirements on homes, schools, and communities to do their share in safeguarding children, but overlap, disagreements, and redundancies are not unusual as children move from one setting to another.

The home, school, and community each have a role in keeping children physically safe and ensuring safeguards are in place so that children are not put at risk from the many potential dangers in the modern environment. Families and teachers also have a responsibility to appropriately educate children about health, safety, and wellness practices.

Protecting children from abuse, violence, bullying, and other aggressive acts is also a shared responsibility involving all three social settings. Children exposed to violence will need care and attention in order to learn.

Ensuring that children benefit from their interactions with media is another area where families, schools, and communities need to partner. Ensuring that children spend appropriate time with media, view content that is suitable for them, and engage with others respectfully in the online environment are mutual responsibilities as well.

Education and protection are enhanced when strong cooperation and alliances exist among homes, schools, and communities. When educators identify the places where involvement by parents and the larger community will help, the outcomes for children are enhanced. However, if the school as an institution neglects to urge and then support cooperative action among all social institutions, protecting and safeguarding children will be difficult to realize.

How Does Learning About this Topic Help You Become a Better Teacher?

As a trained professional with daily contact with children, you are in a unique position to protect them and ensure their safety. By monitoring your students for inappropriate health practices, undesirable social behaviors, and possible maltreatment, you will be able to provide or secure the help children may need. As a teacher, you can also educate children about healthy foods, the importance of exercise, and media safety. We hope we have convinced you of the importance of working with families and the community to ensure children's safety and well-being.

Suggested Activities and Questions

1. Figure 6-1 lists the most common safety hazards for young children in the home. Develop several preventative strategies for each hazard.
2. Determine your state's statutes regarding child maltreatment. Itemize the steps you are to take in reporting suspected abuse, then discuss with a teaching colleague your responsibility and its implications.
3. Locate some of the children's books related to bullying that are found in the Appendix. Determine how you would use one or more of these books to spark a discussion with children about bullying.
4. Before 1980, the Federal Trade Commission (FTC) had the authority to regulate advertising to children, and many restrictions were put in place to protect children from advertising that was misleading and deceptive. When the FTC tried to establish a law that would ban all advertising to children, lobbyists for corporations convinced Congress to strip the FTC of all power to regulate advertising to children. How do you feel about the amount and kind of commercials and advertisements that children see every day? Should children be protected from marketing? Why or why not?
5. Conduct an internet search of an issue related to protecting and safeguarding children to locate some grassroots organizations devoted to this issue. How do these collaborative groups protect and safeguard children?

Resources and Websites

American Academy of Pediatrics

American Society for the Positive Care of Children

Child Welfare League of America

National Coalition Against Domestic Violence

Safe Kids Worldwide

The American Public Health Association is the oldest professional health organization in the world. It serves as a public voice on health care and health-care funding.

The Centers for Disease Control and Prevention has a large variety of online sources and recommendations about diseases, healthy living, lifestyles, and demographics, plus emergency measures.

The Child Trends Data Bank provides a great deal of information on children's well-being.

Common Sense Media has extensive recommendations for parents on movies, books, and internet material. It also has programs for school use.

Defending the Early Years advocates on behalf of appropriate educational practices for young children.

HelpGuide provides unbiased, reliable information about a variety of health issues.

StopBullying provides helpful information for community members, parents, educators, and children on preventing and responding to bullying and cyberbullying.

The National Domestic Violence Hotline provides help to victims of domestic abuse 24 hours a day, 365 days a year.

WiredSafety is the largest and oldest online safety, education, and help organization.