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# Learning Guide 1.5 Interaction-

# Voices from the Field

## **Objectives**

* Identify practitioners’ and families’ strategies and considerations for interacting with children who might have experienced abuse and neglect, children with low-incidence disabilities, and children with disabilities.

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| **Related Content:** [Module 1, Lesson 4 Voices from the Field](https://rpm.fpg.unc.edu/module-1-interaction/lesson-4-voices-from-the-field)  **Instructional Method:** Discussion and Discovery  **Level:** Intermediate  **Estimated Time Needed:** 20 minutes  **Learner Form:** Transcripts |

## **Description**

In this activity, learners will identify strategies and considerations that will help inform their practice for working with children and families from special populations. Learners will work together to create an email correspondence letter to send to the practitioner/family member.

## **Materials/Resources**

* Voices from the Field transcripts for Module 1

## **Facilitator Instructions**

1. Break learners into four groups (if the class is larger than 16 students, choose two groups to work on the same transcript). Provide each group a copy of one “Voices from the Field”| transcript.
2. Allow time for learners to discuss the points made by the practitioner or family member using the following guiding discussion questions:
   1. What did this practitioner or family member say that resonated with any experiences you have had working with young children?
   2. What have you learned about working with special populations (i.e. children with low-incidence disabilities, children who have experienced abuse or neglect, etc.)?
   3. How do you think engaging in interactions with special populations of children will be different based on your new found understandings?
3. Instruct learners to draft an email (individually or collectively) to the practitioner or family person describing how their insight will help inform their practice and asking two questions about working with children with disabilities in a cultural context, children with low incidence disabilities, children who have experienced abuse or neglect, or peer-to-peer relationships.

## **Suggested Assessment**

None

## **Distance Learning Tips**

* Allow groups to respond to questions after listening and/or reading the transcript in online forums.
* Email drafts can be done individually.
* Provide timely feedback.

**Dr. Jeannette McCollum**

**Q1: Why is cultural context important to understanding responsive interaction intervention with young children with disabilities and their families?**

Cultural context has everything to do with responsive interaction intervention, since family members are often central to this approach to intervention. Values, expectations, and norms of interaction vary across cultures for children at different ages, and may also vary when children have disabilities. Different views of what is appropriate and valued in children in general and in children with disabilities in particular will influence how we interpret what family members do with children, and will guide our own approaches to interaction and intervention. For example, how family members perceive their children's current and future abilities and roles may determine when, where, and with whom responsive interaction intervention should occur. Cultural perspectives of intervention itself may influence how interventionists go about planning and implementing the intervention. For example, they may form the context for whether and how we use intervention strategies such as demonstrating, coaching or modeling.

**Q2: What are two-to-three tips for fostering culturally responsive interaction opportunities with children with disabilities?**

The whole idea of being sensitive and responsive can be a useful intervention guide here as well. One tip is to learn about, through observation or discussion, with whom, when, and where the target child is most likely to engage in interactions with adults and with siblings or peers. With whom is the child most likely to engage in pleasurable interactions that have the qualities of turn-taking, whether verbal or non-verbal? Are there adult-child or child-child interactive games or other high-interest activities that are common in that family's cultural context that might provide the basis for responsive interaction intervention? Many high-interest activities may already incorporate aspects of responsive interaction such as imitation and turn-taking, and can become the basis for intervention. In what other contexts do interactions naturally occur? Are there adult-child routines into which communicative opportunities can be embedded through using strategies such as waiting for attempts by the child?

A second tip is to observe the child during different types of interpersonal interactions, WITH the adult as an observation partner. When the child is engaged in activities in which s/he is interested, in adult-child games, or with another child, how does she respond? What is she feeling and communicating, and how do we know? How and when does she initiate or try to maintain interactions? Might some of these ways of initiating and responding be reflective of cultural norms, as well as of the child's individual differences? Sharing observations with the adult can lead to better understanding of the child's interactions for both the family member and the practitioner, and can provide a better foundation for planning appropriate opportunities and interventions that respond to and support cultural context.

**Dr. Rashida Banerjee**

Before we talk about interactions to support young children with low incidence disabilities, let us first understand what’ low incidence disabilities’ mean. Low incidence disabilities include blindness, low vision, deafness, hard of hearing, deaf-blindness, significant developmental delay, complex health issues, orthopedic impairments, multiple disability, and acquired brain injury—which together comprise less than 2% of all children with disabilities, ages 3-21 in the United States. Children with low incidence disabilities learn and develop at varying rates and appear to follow different developmental sequence than their typical peers.

**Interactions with children who have low incidence disabilities can look different form interactions with typically developing children. What are some examples of how children with low incidence disabilities may try to engage with others? And what can practitioners do to build on these interactions?**

When working with or teaching young children with low incidence disabilities, it is important to note that their sensory inputs are altered--especially for children with visual impairment, hearing impairment, and deaf-blindness. Their sensory inputs may be:

* discrete – happen once
* fragmented –not connected to each other, and/or
* intermittent—happen without being predictable

Children with low incidence disabilities often rely on Inductive learning. For example, children with visual impairment rely on tactual input, which means you can only feel so much as your little hands will allow at one time. Then you have to somehow put all these little pieces into a whole. This is the opposite of how other children learn – they see the entire gestalt, as it were, before breaking it down into pieces. It’s a higher level skill to reason inductively.

For example, in order to promote cognitive development of a child who has visual impairment, an early interventionist may provide concrete objects to teach a child different concepts. For example, the visual impairment specialist may use a real dog to teach the child what a dog is by helping them touch its face, legs, nose, body, paws, etc. while making comparisons and talking about relationships. Then, she uses a stuff dog to tell the child about a whole dog.

Incidental learning is limited and cannot be relied upon for children with visual impairment or deaf blindness as they may be unable to copy or imitate others’ visual gestures because they cannot see it. Similar difficulties arise for children with hearing impairment when imitating verbal sounds or with children with multiple disabilities when imitating motoric movements.

For example, in order to promote social communication development of a child with multiple and significant disability, the speech language pathologist uses a communication device to assess a child’s preferences and interests and uses this knowledge to increase the child’s engagement and to promote interaction with peers during meal time.

**Dr. Catherine Corr**

**Q1: What about young children who have experienced abuse, neglect, and or trauma?**

The DEC Interaction Recommended Practices are the foundation for promoting the development of a child’s language, as well as their cognitive and emotional competence. Interactional practices are the basis for fostering all children’s learning. However, for children who have or at risk for developmental delays or disabilities, these practices represent a critical set of strategies for fostering social-emotional competence, communication, cognitive development, problem-solving, autonomy and persistence.

We consider the first six years of a child’s life as critical to his/her growth and development. However, we don’t often recognize that this same period is also the most vulnerable period for young children. Young children are the most frequent victims of child maltreatment. Child maltreatment falls into a number of categories:

* Physical abuse refers to a non-accidental physical injury (e.g., hitting, kicking, burning, etc.) by a parent or other caregiver in the parenting role.
* Neglect is the failure of the parent or caregiver to provide for the child’s basic needs—food, shelter, supervision, medical care, and/or emotional nurturing.
* Sexual abuse refers to not only forcing or coercing a child to engage in sexual activity but also to exploitation through pornography.
* Emotional abuse is usually a pattern of behavior that hurts a child’s emotional development (e.g., constant criticism, threats, withholding love, etc.).

**Q2: What’s the big deal about abuse and disability?**

There is a strong connection between disability and abuse. Meaning, if a young child experiences abuse, they have a higher likelihood of developing a disability or developmental delay. If a young child has a disability or developmental delay, they are at a high risk for experiencing abuse and neglect. This connection is important when we think about supporting young children with disabilities.

**Q3: How do you support young children with disabilities who have experienced abuse?**

When caregivers and parents foster protective factors it can lessen the negative effects of maltreatment. Early childhood professionals can play a large role in this work. By promoting a strong and secure emotional bond between children and their caregivers is critical for children’s physical, social, and emotional development, including their ability to form trusting relationships, exhibit positive behaviors, and heal from past traumas. The healing process is not always a clear, straight path, and it takes time. Note many of these practices are good early childhood practices we recommend for all children regardless if they have experienced abuse, neglect or trauma.

* Build strong connections with friends, family, and teachers that can support children during challenges and teach them to think about and consider other people’s feelings.
* Allow children to feel their feelings. Teach them how to describe those feelings.
* Be consistent. This will help to teach your child that people can be trusted.
* Be patient. Children’s reactions to trauma vary as widely as the types of trauma one can experience. There isn’t one solution. (Child Welfare Information Gateway, 2013)

**Q4: As an early childhood professional, I know I am a mandated reporter, but how does abuse, neglect, and trauma impact my day-to-day work supporting interactions?**

As an early childhood professional, you may know that you are a mandated reporter. But how does this actually impact your day-to-day work? In lots of ways! Below we’ll talk about two case examples.

Let’s consider **INT1:** Practitioners promote the child’s social-emotional development by observing, interpreting, and responding contingently to the range of the child’s emotional expressions.

**Oscar** is a 5-year-old with Down syndrome who was removed from his biological family because of neglect. He was recently placed in a foster home. Oscar’s preschool teacher called his foster home to explain that Oscar is regularly coming to school upset. For the past two weeks, Oscar enters the classroom in the morning crying and doesn’t actively participate in the classroom activities. Oscar’s teacher decided to create a morning routine where she and Oscar have special one-on-one time reading a book in a quiet place to ease him into the morning routine and to make him feel safe and secure. If Oscar’s teacher just wanted to ignore this “needy” or “attention-seeking” behavior, she would not be meeting Oscar’s needs. In this instance Oscar’s teacher not only needed to understand his behavior but she also needed to understand the context of Oscar’s life in order to appropriately support him and his emotional development in her classroom.

Let’s consider **INT2:** Practitioners promote the child’s social development by encouraging the child to initiate or sustain positive interactions with other children and adults during routines and activities through modeling, teaching, feedback, or other types of guided support.

**Marina** was a typically developing 13-month-old living with her mother. While under the supervision of a babysitter one evening, Marina was scalded in a bathtub. Immediately after the incident, Marina was cared for in the emergency room. Shortly after that, Marina began receiving early intervention services. Marina’s OT needed to not only understand child development and interaction, she also needed to understand the complex relationship Marina and her mother had because of this incident. After the incident, Marina’s mother was extremely depressed and upset. Marina’s mother felt any time Marina cried, it was her fault for “not taking better care of her.” While Marina’s mother had good intentions, Marina’s OT had to delicately explain why it was a good thing Marina would cry and express emotions (other than happiness). In this instance, supporting interactions required knowledge of child development as well as understanding the emotionally taxing situation the parent was going through. If the OT ignored this, her interactions and approaches could have been, at best, ineffective and, at worst, inappropriate for Marina and her mother.

No two cases of child abuse and neglect are alike. Every child and family will require flexibility, responsiveness, and astuteness.

**Samtra Devard**

The role that typical peers played in my daughter’s early education program made a huge impact on the growth we were able to see in my daughter’s development. I was not able to anticipate the impact beforehand. But taking that leap of faith, coupled with a great early educator – our daughter had a wonderful experience.

Peers provided my daughter with an example of what a child her age might be doing. The goal wasn’t for that peer to be an example or even set the standard for how my daughter should be. But it was a person with whom my daughter had something in common – their age. It is important to note that while peers serve a wonderful benefit for children with disabilities, there is a benefit for children without disabilities as well.

The kids just had welcoming, accepting hearts! They genuinely want to just play with my daughter. And my daughter could check out what kinds of things they were doing. And her natural desire to connect and remain connected was a natural motivator for her to do some of the things we wanted to see her do.

The teacher made all of the difference! While a special educator, the teacher was simply a good open-hearted person who valued all of the children equally. It was obvious! While she valued them all equally, she recognized and gladly met each of their unique needs.

My daughter’s teacher convinced me that we should embark on the journey of potty training my daughter. And we succeeded! The teacher led the way. She would provide cues when other students asked to go to the bathroom. Things like – “Look at Katie. She has to use the bathroom. Do you need to use the bathroom?” This pointed out action and also an opportunity to enhance communication.

Over the course of the school year, things we wanted to see happen began happening. And equally important, my daughter was making friends.

At those young ages, play is the great equalizer. All kids want to play and that is how essential skills and social interactions are fostered. All kids can be shy. Adults have to keep an eye out for any child (whether they have a disability or not) who seems to be excluded. That exclusion could be resulting from their own withdrawal or the exclusion could be happening because the students need help with how to connect with an individual child. But the important ingredient is for the culture of the classroom culture to already be established as one that is welcoming, accepting, respectful and kind. We were able to see our daughter help cultivate even greater empathy, compassion and confidence in the children who had no disabilities. Our daughter always had great manners. She was able to model things like saying please and thank you for other kids!

One thing that I can see now is that early childhood settings and schools are the starting place for connections to happen. For those benefits to be long lasting, those connections have to be cultivated outside of the school setting into other areas of life. Birthday parties, playdates and other community activities should be encouraged so that there is a long-term benefit that can be realized.

But even if the relationships with the people she met early didn’t last, the skill of making friends and being in new settings has remained. I can see my daughter’s willingness to meet new people, to not shy away from a new experience and to make connections. She is very empathetic so she is able to bring a positive energy to people.