Educational Needs Of Differently Abled Children

Unit Structure

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5.0 OBJECTIVES

After reading this unit you will be able to;

- Explain the meaning of learner diversity
- Enumerate the characteristics of exceptional children
- Describe the educational requirements of exceptional children
- Explain the role of the teacher in dealing with exceptional children
- Explain the concept of Inclusive Education in the Indian context

5.1 INTRODUCTION

The interplay between heredity and environment has created this beautiful world which abounds in human diversity. Individuals differ from each other in their physical, intellectual, emotional and behavioural traits. This creates a confounding situation before a class room teacher where in he/she has to deal with students of different ability levels, emotional and attitudinal make up and of varying physical characteristics within the given time frame to fulfil academic responsibilities.
Catering to individual differences in the classroom thus proves to be the greatest challenge before the teacher.

A typical child in a classroom can either be a normal child with average capabilities or an exceptional or differently-abled one requiring more attention from the teacher.

5.2a CATERING TO INDIVIDUAL DIFFERENCES

i) Cognitively Exceptional Children

ii) Physically Cognitively Exceptional Children

iii) Socio-Culturally Exceptional Children

Who is an exceptional child?

An exceptional child is the one whose performance deviates from the norm, either below or above, to such an extent that special educational programmes and intervention strategies had to be planned to fulfil their academic needs.

Types of Exceptional Children:

Students can be broadly classified to the following three categories:

a) Cognitively Exceptional Children

b) Physically Exceptional Children

c) Socio-Culturally Exceptional Children

COGNITIVELY EXCEPTIONAL CHILDREN

The children belonging to this category can be further subdivided into the following types:

i. The Gifted

ii. The Mentally Retarded

iii. Children With Learning Disabilities

Gifted Children:

Children possessing high intellectual level and special abilities and talents are regarded as gifted.

According to Guilford, ‘the gifted are those students whose potential intellectual powers are at such a high ideational level in both productive and evaluative thinking that it can be reasonably assumed, that they could be the future problem
solvers, innovators of the culture if adequate educational experiences are provided.

**Characteristics of Gifted Children:**

- **Physical Characteristics:**
  By and large, these children have superior physical abilities like-
  1. Greater birth weight,
  2. Early walk and talk,
  3. Early puberty,
  4. Superior motor ability, etc.

- **Intellectual Characteristics:**
  1. High IQ,
  2. Precocious,
  3. Varied interests,
  4. Higher scholastic performance,

- **Personality Characteristics:**
  1. Ambitious,
  2. Higher levels of motivation and enthusiasm,
  3. Impulsive,

**Identification of the Gifted:**

- Parents, teachers and social workers can help in identifying gifted children at a very early date. Careful observation of the child in different setting and for considerable amount of time has to be worked out for early detection of giftedness.

- General intelligence tests, creativity test, word association test, Achievement tests serve as useful tools.
School records, report cards also provide valuable information on giftedness.

**Education of the Gifted:**

The two major approaches to teaching gifted are acceleration and enrichment.

- **Acceleration:** These programmes allow gifted students to move ahead at their own pace, even if this means jumping to higher grade levels.
- **Enrichment:** These programmes allow the students to remain in the same grade but provide special programmes and special activities to cover the topics in greater detail and depth.

It is generally agreed that the education of the gifted pupils should emphasize the following objectives to cater to their giftedness.

1. Analytical perception
2. Methods of problem solving
3. Employing Analysis & Synthesis
4. Conceptual Thinking
5. Scientific Objectivity
6. Originality and creativity
7. Independent study habits
8. Encouragement of special interests

**The Mentally Retarded Child:**

The American Association of Mental Deficiency states that mental retardation exists when there is significant sub average general intellectual functioning existing concurrently with deficit in adaptive behaviour and is manifested during the developmental period.

This means that people classified as mentally retarded can range from those who can be trained to work and function with little special attention to those who are virtually untrainable and do not develop speech and the rest of the motor functions.

There are four levels of mental retardation. They are:

1. **Mild Mental Retardation (IQ 50-70)**
   
   This is the largest group of people comprising of 80% retarded population. They are ‘educable’ and do not show the
signs of brain pathology or other physical defects. Their retardation, therefore, is not identified, at times, even after reaching school, although their early development is often slower than the normal. It can become apparent only when the child starts lagging behind the peers in school work. With early detection, parental assistance and appropriate training, these students can reach a third to sixth grade educational level. Although they cannot carry out complex intellectual tasks, they are able to take up manual jobs and jobs involving inferior skills and function quite successfully and independently and become self supporting citizens.

2. Moderate Mental Retardation (IQ 35-49)
   This group consists of about 12% of retarded population. These are ‘trainable’ and their retardation is evident early in their lives. They are slow to develop language skills and their motor development is also affected. Some of these students could be taught to read and write and speak some broken language. Physically, they are clumsy and suffer from poor motor coordination.

3. Severe Mental Retardation (IQ 20 -34)
   This is the group of ‘dependent retarded’ consisting of 7% of retarded population. These are the children with severe problems of speech retardation and sensory defects and motor handicaps are common.

4. Profound Mental Retardation (IQ under 20)
   They belong to the category of ‘life support mental retardation’ consisting of 1% of the retarded population. Most of these are severely deficient in adaptive behaviours and unable to master even the simplest of tasks. Severe physical deformities along with convulsive seizures, mutism, deafness and other problems are common. Such a person has a very short life expectancy.

Causes of Mental Retardation:

Biological Causes

- In about 25 % to 35 % of the cases, of mental retardation, there is a known biological cause. The most frequent being the presence of an extra chromosome causing
Down’s syndrome. The frequency of this disorder increases with the increasing age of the mother.

- A birth complication like inadequate supply of oxygen to the brain is another major cause of biological mental retardation.
- Many cases of mental retardation are classified as ‘familial retardation’ where there is no known biological cause, but there is a family history of retardation.
- Cretinism is retardation due to endocrine imbalance like failed thyroid or degeneration of thyroid.

Infection & Toxic Agents:
Presence of carbon monoxide, syphilis or germ measles with mother can cause retardation in the foetus. Incompatibility between the blood types of the mother and the foetus, drugs taken by mother during pregnancy could result in mental retardation.

Prematurity and Trauma:
Babies weighing less than 1500 grams at birth, difficult labour, bleeding within the brain of the babies are some other causes.

Ionizing & Radiation:
Radiation may act directly on the fertilized ovum or may produce mutation of the sex cells of either or both parents, which may, in turn lead to defective offspring.

Malnutrition:
Protein deficiency in mother’s diet during the last five months or in the diet of the child during the first 10 months after birth can cause great harm to child’s brain.

Teaching the Mentally Retarded
There are a number of areas, in which mentally retarded have specific difficulty, including attention span, memory, learning rate, ability to generalize, and conceptualization.

Providing great deal of practice, making the child rehearse actively the learning material to be memorised, may improve child’s retention considerably. Over learning is another useful strategy to deal with the problem. Finally, the teachers should realize that the curriculum goals and objectives should be
adjusted to suit the needs of the special child. The emphasis should be on teaching the kind of skills that will best enable the child manage himself or herself independently in the society.

**PHYSICALLY EXCEPTIONAL CHILDREN**

The term physically exceptional has been used in literature in various ways: Physically disabled, crippled, orthopaedically impaired, or otherwise health impaired. Physical handicaps are divided into two types: Orthopaedically handicapped (OH) and Health impairments for the purpose of special education (Bigge and Sirvis, 1986). The legal definition of the term orthopaedically handicapped is a severe, orthopedic impairment that adversely affects a child’s educational performance. The term includes impairments caused by a congenital anomaly e.g., club foot, absence of some body organs, impairments caused by disease, e.g poliomyelitis, bone tuberculosis, and impairment from other causes e.g. cerebral palsy, amputations, and fractures or burns that cause contractures.

The legal definition for other health impairments is having an acute condition that is manifested by severe communication and other developmental and educational problems, or having limited strength, vitality or alertness because of acute health problems e.g., heart condition, tuberculosis, rheumatic fever, nephritis, asthma, anaemia, haemophilia, epilepsy, lead poisoning, leukaemia or diabetes that adversely affects a child’s educational performance.

However, there are certain neurological disorders which are not categorized as either crippling or a special health problem e.g. aphasia – a language disorder due to brain injury. Hence, from an educational point of view crippling and neurological impairments would include all children with non-sensory physical impairments whether they are accompanied by a neurological damage or not, and whether they resulted in chronic health condition or not.

Basically non-sensory physical impairments may be classified as crippling and chronic health ailments. The cripples have muscular and skeletal deformities which are obvious. They may wear braces, prosthetics devices such as artificial limbs or may be moving with crutches or wheel chairs.
A teacher or educator is less interested in the physical aspects of disability but he is more concerned with the manner in which it will affect the child’s functioning in learning situation.

a. Children with muscular or neuromuscular handicaps which significantly limit their ability to get about, sit in the classroom, manipulate the materials.

b. Children with skeletal deformities which also affect movement, posture and use of hand in school work.

c. Children with temporary or chronic lack of strength, vitality or weakness.

The categorization of orthopaedic disability according to extent and severity:

- Mild -- < 40%,
- Moderate – 40% and above
- Severe – 70% and above, and,
- Profound – 100%

Prevalence

It is estimated that physical handicaps occur to the tune of 2%. The most common physical impairments found in school are Cerebral palsy, Spina Bifida, and Muscular dystrophy. The National Sample Survey 1991 puts it at 8.939 million in India (orthopaedic) out 16.15 million of the physically handicapped in 80:20 rural-urban, and 60:40 male-female ratio. In 1981 physically disabled were 1.94% and 1.42% for rural and urban population respectively. The corresponding figure in 1991 NSSO was 1.99% and 1.58% respectively.

Causes

The causes for physical handicap are many and varied. Brain damage, brain fever and brain anoxia lead to physical disability. Rh-incompatibility, intoxication, viral infection for the expectant mother may also causes physical disability. Similarly, prolonged labour, lead poisoning, accidents may cause damage to the brain leading to neurological disorders. Polio, Burns and injuries are significant causes as per NSSO, 1991 for Indian society.
Identification

One or more of these disorders are manifested in the children who are physically exceptional:

1. Deformity in fingers, legs, hands, spine, neck.
2. Frequent pain in joints
3. Jerking movement in walking
4. Amputed limbs
5. Difficulty in sitting, standing, walking
6. Poor motor control
7. Shaky movements
8. Difficulty in picking, holding and putting things.

Characteristics

Physically handicapped students generally have average or above average intelligence. Dykes (1984-85) suggest 85% of health impaired and 35% of orthopaedically handicapped children are served in special schools or classes. Often their needs vary. The greater needs of the physically handicapped children are in the areas of adaptive equipments. Often they require wheel chairs, crutches, head pointers, arm and leg braces. Technological gap has narrowed down the gap in providing adequate educational instruction to students who can not speak move or use hands.

Physically handicapped children are passive, less persistent having shorter attention span, engage them in less exploration and display less motivation. They are more dependent on adults, and interact less with peers. Facilitating independence and building self esteem are the two requirements for the physically handicapped children.

The physically disabled has poor body image, high anxiety, and frustration. They are found to be quiet, conforming, tender minded and somewhat tense. Social relationships constitute a problem area for many crippled youngsters. Their capacity for frustration tolerance is lower than normal children.

Difficulties of orthopaedically handicapped arise out of several factors. Essentially children with motor disabilities are not very different from normal boys and girls. Their handicap arises out of three factors:
a. Society’s attitude towards them.
b. Child’s interpretation of this reaction to his limitation.
c. Discrepancy between aspiration and achievement.

Because of neurological impairment and experimental impoverishment they do show perceptual difficulties.

Intelligence of the orthopaedically handicapped children does not basically differ from those of normal except for cerebral palsy. The neuro-muscularly impaired children function 10 to 15 points between estimated intelligence. Children with cerebral palsy, muscular dystrophy, and hydrocephalic are included in the dull normal classification while other children with the orthopedic disability are within the normal range.

**Educational Provisions**

Orthopaedically handicapped children do not need any special situation for schooling. They can be educated well in the regular school along with others. The regular classroom teacher can well handle such cases.

**Integrated Education**

Education of OH children has changed considerably over the past 50 years. Programs of children with orthopaedic handicaps have broadened extensively to include the process of rehabilitation. This is studying the total child. Each staff member has to participate and show sensitivity and natural respect.

Special educators need specific preparation for their team work role. The teacher's function include (a) diagnosis of deprived experience and provision of what is essential (b) developmental guidance (c) coordination of habilitation programme, (d) promotion of integrated activities (e) maintenance of reality standards and discipline. Attention should be given both to individual and group in planning differential diagnosis. It means understanding and the study of all factors of the child’s growth and his development. For example, if a child has IQ 60 and serious emotional problems due to family stress and pressure, it is not a simple case of past polio. In the total programme the vocational rehabilitation counsellor also assumes major responsibility.
Partial integration is possible in special class especially if the unit is desirably located in a public school building.

The child's likelihood of success in regular classroom setting appears efficient when

a. the child is intellectually, socially and emotionally capable of participation with his peers,
b. the child can participate,
c. the child is not being denied therapy necessary for physical rehabilitation,
d. the curriculum is adapted to most of his needs,
e. the physical facilities of the school permit the child to hence access to important educational centres,
f. the teacher is willing to accept the child and prepared to move with one who deviates physically,
g. adequate physical assistance and special supervision is provided
h. periodic evaluation is included in the child’s progress report,

What criteria should be used to place physically impaired children in the integrated school? The following criteria seem pertinent:

1. Average or above academic ability
2. Social and emotional ability
3. A desire to be integrated
4. Support of parents
5. Ability to communicate effectively

**The Regular Teacher**

For physical disability the regular teacher need to make instructional adaptations so that the children communicate with teachers well. For Health Impairment he has to know the basic characteristics of disorders, medicine and their effects, precautionary measures, keeping a watch on day to day requirements and develop appropriate expectations so that children do not suffer from identification.

Three factors are responsible for deciding the teaching procedures of physically and/or neurologically impaired
children namely; Task analysis, teaching towards developing independence, and use of computer instruction.

The type of content is dependent upon the degree of physical impairment. Yet certain areas are most essential.

a. Communication skills and language
b. Activities of daily living, or self care skills (eating, bathing etc.)
c. Community referenced instruction (crossing streets, using money, riding public transportation)
d. Advanced self care skills or home living skills (operating kitchen appliances etc.)
e. Vocational preparation, career awareness, works adjustment skills.
f. Continuity and generalization.

**SOCIO-CULTURALLY EXCEPTIONAL CHILDREN**

Educators categorize socio-culturally exceptional children somewhat arbitrarily into one or more of the following areas of deprivation: economic, racial, geographic, social, cultural, cognitive, and/or emotional. Historically one can identify the roots of this population in terms of their educational needs, but it was not until the mid 1960s that writers such as Riessman and Havighurst had their turns at defining the characteristics that constitute this deprived population. As indicated by Reissman (1962), the terms culturally deprived, educationally deprived, under privileged, and disadvantaged, lower class, and lower socio-economic group, could all be used interchangeably.

The disadvantaged children differ from advantaged class in mainly six areas.

**They are:** self-concept, motivation, social behaviour, language, intellectual functioning and physical fitness.

Specific learning characteristics of the deprived or disadvantaged student might include many of the following:
(1) orientation towards physical and visual rather than to the oral;
(2) content-centered rather than introspective;
(3) problem-centered rather than abstract centered;
(4) inductive rather than deductive;
(5) spatial rather than temporal;
(6) slow, careful, patient, and persevering rather than quick, clever, facile and flexible;
(7) inclined to communicate through actions rather than words;
(8) deficient in auditory attention and interpretation skills;
(9) oriented toward concrete application of what is learned;
(10) short attention span;
(11) characteristic gaps in knowledge and learning;
(12) lacking experiences of receiving approval for success in tasks.

Meeting the needs of the disadvantaged child is a relatively new educational approach.

Causes
Cultural deprivation or disadvantaged arise due to a complex set of conditions which create intellectual deficiency in a child. Some of these conditions are attributed to unstimulating environment, lack of verbal interaction with adults, poor sensory experience, and other deleterious environmental factors generally associated with poverty, low social status, malnutrition, broken homes etc.

Behavioural Signs for Observation
The term ‘disadvantaged’ is used to indicate observable behaviours. They are-

a. Progressive decline in intellectual functioning in school.
b. Cumulative academic achievement deficits.
c. Premature school termination and high drop out rate.
d. Reading and learning disabilities.
e. Poor language learning.
f. Inadequate social learning and observation in the absence of model,
g. Low attention span and distraction in learning.
h. Lack of proficiency in higher form of cognitive learning and transfer.
i. Inability to classify and form logical concepts, incapacity to verbalise events and solutions.

j. Lack of analytic ability which is essential for learning.

k. Belief in external factors, i.e., luck, chance, fate etc. rather than their own self and activity.

l. Cannot delay gratification. Immediate tangible and non-contingent rewards are their needs.

m. A high sense of avoidance for failure than striving success.

n. Poor self concept, low achievement aspiration, and low need achievement including lack of desire for self actualization.

o. General behaviour lacks intrinsic motivation. Insecurity and anxiety are very obvious.

**Assessment of Social Disadvantage**

In order to identify social disadvantage the following scales and tests may be used:

1. Deprivation index – Whiteman and Deutsch (1968). This scale even though developed in USA yet is of relevance after appropriate adaptation.


3. Prolonged Deprivation Scale – Misra and Tripathi (1977). This is most relevant and appropriate but needs shortening in terms of the length of the test. It relates to 15 areas of socio-cultural experiences.

   - Housing condition
   - Home environment
   - Economic Sufficiency
   - Food and Nutrition
   - Clothing
   - Educational Experience
   - Childhood Experiences
   - Rearing Experiences
   - Parental Characteristics
   - Interaction with parents
   - Motivational Characteristics
   - Emotional Experiences
Characteristics of Disadvantaged Children

What are the characteristics of the disadvantaged children? These children show poor academic performance and high drop-out rates, reading and other learning disabilities and have adjustment problems. They have lower grades, their health is poor, and they have deficiencies in the two most skills namely, reading and language, necessary for success in school. They have minimal training in disciplined group behaviour and educationally they are less ambitious. Children from impoverished environments are apt to have various linguistic disabilities. They also show incapacity in cognitive processes such as: the ability to observe and stating sequences of events, perceiving cause and effect relationships, classifying concrete objects, attributing responsibility to self and in general have poor self concept. The combination of non-verbal orientation and an absence of conceptualization well account for their intellectual deficits and deficit in cognitive skills or in Piagetian terminology, formal logical thinking is absent in all such children or appear very late in the development. The consequences of the cognitive deficiencies are again complicated by their pattern of motivation and attitudes. Psychologists explain that these children have a feeling of alienation induced by family climate and experience combined with a debilitating low self concept. They tend to question their own worth, to fear being challenged, and to exhibit a desire to cling to the familiar. They have many feelings of guilt and shame. These children are wary of socialization and their trust in adults is limited. They make trigger like responses and are hyperactive.

The lower achievement of disadvantaged children could be attributed to at least five causes: malnutrition, genetic, lack of stimulating early experience, social motivations and cultural values.

In India, social and cultural disadvantage is not very clear cut. All low income group children are not necessarily at disadvantage. The high caste is supposed to have a culture superior to that of the low caste Harijan given the same low economic status. The cumulative effect of these widens the gap
between Brahmins and Harijans. There are empirical findings which support the cultural effect of a high caste home.

**Remedial measures**

In order to reverse the ill effects of deprivation, certain remedial measures are recommended. They are:

a. Early modelling and imitation of desirable behaviour  
b. Language enrichment programme and stimulation at home  
c. Affective attention and acceptance  
d. Providing initial success experience to build better motivation and striving for success.  
e. Removal of discrimination attitudes on the part of teachers and other significant members of society  
f. Humanistic approach to teaching the underprivileged in school  
g. Instructional programmes may be geared to their needs and ability level  
h. Giving responsibility, recognition, tangible rewards, positive remarks etc.  
i. Exposure to sensitivity training, exposure to literature, discussion and group contacts, role playing, case conferences relating to their problems.  
j. Presenting learning materials using images, aids, and providing adequate organizers and drill.

Compensatory education programmes have proved the validity of these recommendations.

**Role of Regular Teacher**

The following instructional strategies for educating the disadvantaged are suggested considering the objectives of instructions and their entering behaviour to an instructional situation. Basically, there is no difference in the learning potential between the normal and the disadvantaged group of students. But the teacher should monitor the rate, the sequence, the type of materials and presentation modes. Hence, the need of a few guidelines is obvious.
a. A continuous appraisal of progress and comprehensive measure of assessment-diagnosis via feedback should become a part of every teaching act and basis of planning the next learning experience.

b. If instruction is to be effective these students are to be simultaneously trained to achieve the three objectives: knowledge, skills and attitudes.

c. Since the students come to the school with cognitive deficit a special hour may be kept aside for remedial teaching language, training in how to increase some of their non-intellective characteristics, i.e. self-concept, level of aspiration, n-ach, sense of responsibility etc.

d. Learning of concepts and ideas may be sequenced before they are presented to the underprivileged group, using more of concrete and life like situations. Training for analytic thinking may also constitute a part of the instructional programme design.

e. The imposition of standardized expectation regarding performance should be replaced by more of individualization in the rate of learning and exposure of varied materials. Instructions must be given how to pace performance according to their ability. The teacher has to ascertain the pre-requisites before instructing them to move to the next step.

f. For educating the underprivileged, giving recognition, responsibility, tangible rewards, positive affective remarks encouragement have been found to be effective and are to be encouraged in schools. Affective interactions and developments to be supported in a school programme.

g. They also need to be acculturated through sensitivity training, exposure to literature, discussions and group contacts, role playing and case conferences.

h. Self-instructional materials may be used best to their advantage.

i. The culture specific curriculum relevant to their life, especially for tribal population should be developed and used.
5.2b CONCEPT AND TYPES OF LEARNING DISABILITIES

Learning disability (LD) is a term used to denote a neurological handicap that interferes with a person’s ability to receive, process, store, and retrieve information. LD creates a gap between a person’s ability and performance caused by an alternation in the way information is processed. Repetition and drilling does not alter this processing, but presenting materials in a different way helps. Individuals with LD are generally of average or above average intelligence.

- LD can affect one’s ability to read, write, speak or compute math, and can impede socialization skills.
- Early diagnosis and appropriate intervention and support are critical for the individual with LD.
- Because it is often a ‘hidden handicap,” LD is not easily recognized, accepted or considered serious.
- It is believed that LD never goes away, but can be compensated for.
- Attention deficits and hyperactivity are sometimes coupled with LD, but not always.
- LD is not the same as the following handicaps: mental retardation, autism, deafness, blindness, and behavioral disorders.

It is thought that up to 15 percent of any population anywhere contains learning disabled. Specific learning disabled (LD) persons find it difficult to succeed in conventional classroom. Therefore, it is essential that all teachers, preschool through university, will have LD students in their classes, unrecognized, undetected and therefore considered to be the “dullard,” the backbenchers.

LD is a neurological condition that is beyond the control of the individual. Such a student is more normal than different. There are degrees of LD – mild, moderate, and severe. It might go undiagnosed as late as secondary school, university, or even never at all. They younger the child when diagnosed, greater is
the possibility of remediation. When a student is older, it is coping strategies that need to be strengthened.

**How it Affects the Students**

Learning disabilities affect the child from a variety of angles—mostly, self-esteem and self-confidence. In the very early years, the feedback comes from parents, but since learning at this stage is fairly non-stressful, the occasions for failure are few. The situation dramatically changes when the child enters schools and encounters other children (who are not a brother, sister or a cousin), competition (in an alien atmosphere), and other adults (who are not parents). It is the latter which have a very significant and lifelong impact on all students. This involves not only the teaching of particular academic skills, but as importantly, the fostering of students' self-esteem, that is, to make them feel that they belong and are welcome in the school setting. This can be done in the classroom by providing them with responsibilities through which they perceive themselves as contributing and making a difference (e.g., distributing books to the students, helping younger children during recess, helping make charts for the class). Offering them opportunities to make choices and decisions and solve problems, communicating encouragement and positive feedback will also help the process. While these kinds of positive interventions are important for all students, they are particularly relevant for students who find learning problematic.

Negative experiences in the school, especially in terms of learning incapacity can leave long lasting scars of being demeaned, belittled, or accused of being disruptive as they struggled to understand what was being taught.

**Behavior Problems**

LD can present with hyperactivity and impulsive behavior with lack of reflective thought prior to action. These children have poor peer relationships and poor social judgments. They may behave inappropriately in different situations and fail to see consequences of their actions. They may be overly gullible, and easily led by peers. They show poor adjustment to environmental changes and excessive variation in mood and responsiveness.
Emotional Problems

- LDs often go unrecognized. Children may present with symptoms such as school refusal or agoraphobia, or develop somatic symptoms such as headaches and stomach-aches, especially on the school day they are expected to speak or read in front of the class.

- Undiagnosed and untreated, these problems increase till the child begins to dislike school, refuses to do homework, and perhaps develops oppositional defiant symptoms. Some children may become verbally abusive and physically provocative. Successful intervention with these children requires the diagnosis and treatment of the learning and language problems. Behavioral and emotional problems are more likely to emerge as children mature and academic tasks become more difficult and peer interactions become more complex.

Environmental Causes

These could be poverty, inadequate housing, family dysfunction, and parental psychopathology or substance abuse, dysfunctional peers, too much of television viewing, inadequate or improper schooling.

General Guidelines for Educators

- Students with LD may take much longer to learn and can also tire quickly. They have to try harder, which can be exhausting. Be aware that the pace of the normal class is likely to be too fast because they often need more to process language. Make a conscious effort not to speak too rapidly.

- Be prepared to learn from the parents. Interest, involve, and work closely with them. Use whatever works-home/schools agendas, face-to-face meetings, phone calls or e-mails.

Ensure that information concerning the student is passed on when the students is in transition from one teacher to another and from one year to another. Do not assume that this will be done automatically.

Suggested Strategies
• Encourage students to be aware of and to evaluate the strategies they use to study and to learn. Study skills, like note-taking and time organization, need to be actively taught.
• Provide structure. Lists of the day’s routines and expected behaviors can be great help. Give plenty of warning when changes are made to the timetable, teacher or task.
• Teach how to ask questions. All students, especially the ones with LD, need to feel comfortable with seeking assistance.
• Break activities into small, sequential tasks. Give specific examples.
• Repeat, repeat, repeat – both old and new materials, in different ways.
• Provide the amount of structure and support that the students need.
• Do not expect the students to listen and write simultaneously.
• Mark positively – tick the good bits. Mark for content – not presentation or mark for presentation and not content.
• Do not use playtime to finish work.
• Reward any and all good behavior.
• Very important, seek opportunities to praise and build self-esteem.

The three major types of LD are:

1. **Dyslexia**: A person has trouble understanding written words, sentences or paragraphs.
2. **Dysgraphia**: A person finds it hard to form letters or writes within a defined space.
3. **Dyscalculia**: A person has difficulty solving arithmetic problems and grasping math concepts.

**1. DYSLEXIA**

Dyslexia is a disorder manifested by difficulty in learning to read, despite conventional instruction, adequate intelligence and socio-cultural opportunity. It is dependent upon fundamental cognitive disabilities, which are frequently of constitutional origin.
Characteristics of Dyslexia

- Speech difficulties are common in children with dyslexia. Stuttering and lisping are quite common. Delayed spoken language is often an indicator of dyslexia.

- Spatial difficulties-leading to reversal of letters (B-d), words (saw, was) and sometimes even sentences and difficulty in scanning from left to right.

- Visual memory difficulties in recalling sequence of letters in words (spelling).

- Difficulties in visual and motor figure ground- resulting in illegible handwriting, difficulties in scanning lines and discrimination of letters.

- These characteristics appear more often in combination. Apart from difficulties with phonological processing, dyslexia is also associated with differences in cognition and learning.

Language Problems

Dyslexic children have problems with reading, a lack of awareness of phonemes that make up words, difficulties with spelling, sequencing of letters in words, and difficulty with pronouncing words (may reverse sounds).

- Early warning signs are delay in speech, delay in learning the alphabet, numbers, days of the week, month, colors, shapes, and other basic information. They also have difficulties understanding subtleties of language such as jokes or slang, concept words (forward/backward, near/far) etc. there may be mispronunciations, omission of sounds and immature vocabulary.

- Auditory and visual processing difficulties may also be present. Here children have difficulty distinguishing between words that sound alike (pig/big). There is trouble rhyming words, and in blending sounds into words. Visual processing difficulties may include inability to recognize letters, words, or other printed symbols quickly and accurately. For example, there may be confusion with b and d, or read for saw and on for no.
Motor Coordination

Motor coordination problems are common. These children may be clumsy or awkward. It may be difficult for them to write, draw, or copy with neatness and accuracy. There may be problems with fine motor skills such as tying shoes, buttoning, using scissors or learning to sew.

Diagnosis

Detailed history is most important in making a diagnosis of dyslexia. When dyslexia is suspected, a battery of standardized tests comprising of tests of reading, spelling, language, and cognitive ability must be carried out. Additional tests of academic achievement, e.g., math, language, or memory may be administered as part of a more comprehensive evaluation of academic, linguistic, and cognitive function. The diagnosis is made after careful consideration of the history, clinical observations, and testing data.

Strategies for helping the child with Dyslexia

- Teaching reading and writing simultaneously to enhance language comprehension through visual perception, auditory perception and tactile perception.
- Focusing on most basic perceptual associations that the child is familiar.
- Teaching whole word instead of isolated letters to provide complete language experience
- Planning learning experiences that the child can perform successfully
- Constructing reading experiences that use the skills that the child has learned previously.
  
  Emphasizing on over learning till it becomes automatic

Specific Teaching Strategies:

- Dyslexics should be taught in a structured, logical step-by-step way, beginning with single-letter sound linked to letter names and letter shapes, working in stages through simple one-syllable words to complex multi syllable words.
• The teaching drills should be based on a multi-sensory technique. In other words, an all-around approach that utilizes the student’s senses of sight and hearing, as well as involving writing down and reading back aloud what has been written—an approach that is particularly successful with dyslexics.

• The association between single-letter name, sound, and shapes should be taught first, along with the knowledge of that some of these letters are vowels, which will be needed in every word. Gradually, the complete range of spelling patterns and sentences is taught.

• The teacher should thoroughly understand the structure of the language and how it develops. Dyslexic students should be introduced by dictation to sentence formation in its simplest form.

• Asking the child to repeat sentences while dictating also helps to improve memory for sentences. More sophisticated sentences are introduced gradually.

• Dyslexic students have to be taught reading, and spelling in a scientific manner with every step distinctly clarified and presented in a comprehensible manner.

• In addition to specially tailored reading and writing tuition, specialist dyslexia therapy should also give help, when needed, with mathematics, directional confusion, telling the time and all the other typical problems for the dyslexic.

• This drill is repeated with each set of new sound patterns. The association between single-letter name, sound, and shapes should be taught first, along with the knowledge of that some of these letters are vowels, which will be needed in every word.

• Gradually, the complete range of spelling patterns is taught and sentences. The teacher should thoroughly understand the structure of the language and how it develops. Dyslexic students should be introduced by dictation to sentence formation in its simplest form.

• Asking the child to repeat sentences while dictating also helps to improve memory for sentences. More sophisticated sentences are introduced gradually.

2. DYSGRAPHIA
A neurological-based writing disability in which a person has difficulty expressing thoughts on paper and with writing associated with unreadable penmanship and problems in gripping and manipulating a pencil.

The written form of language is the highest the most complex form of communication. In the hierarchy of language skill, writing is the last to be learned. Prerequisite to writing is a foundation of previous learning and experiences in listening, speaking, and reading. Even though dysgraphia is difficulty with handwriting, the other components of written expression—spelling and written expression which are impaired in children with learning disabilities need to be considered.

**Common Signs of Dysgraphia:**
- Bad or illegible handwriting
- Awkward or cramped pencil grip.
- Avoidance of tasks involving writing.
- Inconsistent in the way letters and words look.
- Difficulty in expressing ideas on paper.
- Inability to properly form letter
- Writing may be slow and labored.
- Difficulty keeping letters on the line.
- Inability to understand the relative sizes of letters.
- Crowding of letters within words.
- Poor spacing between words.
- Difficulty in reading written work even when the spelling is correct.

**Strategies for helping the child with Dysgraphia**

The teacher has to pay attention to the following

**Handwriting Skills**
- Has a good tripod grasp.
- Able to draw horizontal line (left to right) and vertical line (top to bottom).
- Able to draw a circle.
- Copies letters and words

**Writing Letters**
- Place a little green dot at the starting position for the letter stroke and a small red dot at the termination point. Arrow clues to indicate the direction of the stroke could also be provided.

- Teach the basic strokes for most letters sequentially. For example, teach the letter “t” as two separate strokes: and Eventually, encourage the child to join the basic strokes together.

- Teach letters with easier strokes first. The following letters are considered the least difficult for children to learn: c,i,l,o,t,v.

- Tape an alphabet chart to the child’s desk.

- Use clean, lined paper for children with aligning and spacing difficulties.

- Teach children to “talk out” strokes in making specific letters. For example,
  - W - Slant down, slant up, slant down, slant up.
  - I – short line, dot.

**Cursive Writing**

Devise games for students to practice various cursive strokes. For example:

- Stringing beads.
- Making waves
- Making curly hair.

- Use dot-to-dot or dash-to-dash letters to informally assess readiness for cursive writing. Gradually fade out the dots or dashes, allowing the child to make the complete letter independently

- Teach letters with similar movement patterns sequentially. The following four groups contain similar strokes: (1) a,c,d,g,o; (2) b,h,f,k,l,e; (3) i,j,p,r,s,t,u,w; (4) m,n,v,x,y,z.

- Place a heavy (possibly weighted) bracelet or wristband on the wrist of a child who had difficulty keeping his wrist in the proper position on the desk.

- Use verbal cues in teaching cursive writing. Teach letters with similar strokes in sequence so that the child can more easily follow the cues. For example, use the “a”
strokes in teaching the “g” strokes: “First come around like the ‘a’, then go down....”

**Handwriting Activities for Left-handed Students**

Observe whether the child uses the right positioning. The left-hander’s writing should be slightly sloped to the left-tape the student’s paper in the right positioning, if necessary. Seat the child in the left corner of the classroom away from the aisle, if possible, to ensure movement space.

LD students usually encounter many different types of written language problems. They have difficulties in handwriting (formation, size and spacing irregularities, pressure marks and erasures), spelling and written expressions. General competencies required for each of these areas are listed below:

### 3. DYSCALCULIA

Dyscalculia is the type of learning disability resulting in difficulty in learning numerical and mathematical ideas and concepts.

**Clinical Signs of Dyscalculia**

- Difficulty with common math processes such as addition, subtraction, multiplication.
- Difficulty with math concepts such as sequencing of numbers, and sequencing of rules required in mathematical problems.
- Poor retention and retrieval of math concepts.
- Inability to work with numbers or symbols.
- Inconsistency in understanding and application of math rules.
- Poor sense of direction and time, e.g., difficulty with reading maps, telling time, etc.
- Difficulty in applying rules in sports.
- Trouble keeping track of scores and players during card and board games.
- Inability to handle money transactions in day-to-day living.
Difficulties in Mathematics

- Shape discrimination - confusion in recognizing shapes may cause difficulty in recognizing numbers.
- Size discrimination - concepts like, big, small, long and short are very important for mastering abstract quantitative concepts like more, less, greater than, less than, etc. This may also lead to difficulties in estimating area, perimeter, etc., at a later stage.
- Classification - categorizing objects into sets is a very important concept for mastering maths. Difficulties in this can also lead to difficulties in simple operation like counting.
- One-to-one correspondence - lack of understanding of this could cause problems even with counting. This may also lead to failure in understanding ordinal numbers.
- Auditory-visual integration - necessary to remember names of symbols (numbers, signs, etc.). Memory deficits could aggravate the problem.
- Place value - confusion in this area can lead to difficulties in addition (involving borrowing and carrying over), division and multiplication.
- Computation skills - in understanding commutative properties of addition/multiplication and concepts that subtraction is an inverse operation of addition and division in an inverse operation of multiplication.
- Problem solving - difficulties in solving word problems due to problems in language, lack of analysis, and reasoning.
- Spatial concepts - difficulty in making measurements of time, distance, etc.

Strategies for Intervention

- Identifying the problem areas in maths is the first step towards helping the child. Concretizing the concepts, use of multi sensory approach, repeated drill and revision exercises once understanding of the concept is ensured, will help in consolidation and retention. Gradually
increasing the difficulty level of the concepts, using examples from real life and weaving stories around mathematical concepts can be attempted to get the child involved in learning.

- It should be kept in mind that each intervention strategy is a unique instructional design based on the kind of learning difficulty the child has and the nature of the mathematical concept itself. Hence, it implies lot of creativity and imagination on the part of the teacher handling the difficulty.

As an illustration, Strategies for Intervention to clarify some of the mathematical concepts are discussed below.

1. Teaching pre-concepts, mathematical operations

- Prepare a worksheet with missing math signs. Ask the students to fill them in.
- Promote understanding of the terms longer and shorter by drawing lines of various lengths the chalkboard and asking the students to make them longer or shorter.
- Use number line to develop vocabulary such as before, after, between, larger than, smaller than, and the same as. Permit students to refer to the number lines in answering questions (e.g., what number comes just before 7? What number comes just after 13? What number comes between 6 and 8?)
- Give students a set of cards numbered from 1 to 10. Instruct them to turn up one card and ask whether that number comes before or after a number that you choose at random. Also, use more or less and smaller than or larger than for this activity.
- Print operational sign on flash cards. Let the students practice with the cards every day. Add kinaesthetic clues by cutting the signs out of sandpaper and pasting them on the cards.
- Provide colour cues for operational signs to call attention to the signs. Also, draw circles or boxes around the signs to enable students to attend more closely to the signs.

2. Teaching Fractions-
Not only children but many adults also have difficulty in understanding fractions. To understand fractions, we should be aware that:

- Fractions make sense only when viewed in relation to a whole number. They make no sense as independent entities.
- The understanding of the symbols of the fractions: denominator—the number of parts the whole is divided into; and the numerator—the number of parts of whole which are in consideration.

Materials and experiences should be provided to the children to master these basic facts.

- Fraction and equal sharing – give children a bag of marbles, sweets, etc., and ask them to share equally between 2, 4, 8 and 10 children and write the fractional equivalent.
- Fractions and shapes – draw and cut symmetrical shapes and ask children to fold into \( \frac{1}{4} \), \( \frac{1}{2} \), \( \frac{1}{8} \), etc.
- Fractions/length – estimating or measuring length of a long strip, its \( \frac{1}{4} \), \( \frac{1}{2} \), \( \frac{1}{8} \), etc. This activity could be done with capacity, weight, time, etc., for generalization.
- Charts could be drawn to illustrate the relationship of fractional parts to the whole.
- Gradually introduce assignments requiring to work with fraction without visual clues.
- Use the measurements in simple recipes to reinforce fractional components.

### 5.2c EMOTIONAL AND BEHAVIOURAL DISORDERS

i) Attention Deficit Disorder (ADD) & Attention Deficit Hyperactivity Disorder (ADHD)

ii) Disruptive Behaviour Disorder

There is no one single definition of emotional and behavioural disorder as this category of exceptional children covers a range of difficulties from very mild to extremely serious ones. The definition by Bower (1969) is closely related to school situation. According to him, a psychological disorder is said to
be present when the child emits behaviour that deviates from discretionary and relative social norm in that it occurs with a frequency or intensity that authoritative adults in the child’s environment judge, under the circumstances, to be either too high or too low.

The two major groups here are:

i) Attention Deficit Disorder (ADD) & Attention Deficit Hyperactivity Disorder (ADHD)

ii) Disruptive Behaviour Disorder

**ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)**

ADHD is a neurologically based disorder, characterized by developmentally abnormal degrees of inattention, impulsivity, and hyperactivity, ADHD often interferes with the child’s ability to function with success academically, behaviorally or socially. Occasionally misdiagnosed as “emotionally disturbed” or “undisciplined,” these children create havoc at home and school. ADHD causes highly inconsistent performance and output. Children with ADHD live in distraction and chaos all the time - bombarded with stimuli in every direction and unable to screen it out. It can be compared to listening to a lecture in a marriage hall. The child needs tremendous effort to focus on a task.

**Intervention Strategies**

Minor changes in the classroom environment and teaching methodology can go a long way in helping a child to cope with ADHD. Small changes in how the teacher approaches the child or what she/he expects from the child can turn a losing year into a winning one for the child.

**Intervention strategy for Inattention**

**Seating:**

- In a quite area far away from doors/windows.
- Near the teacher (to improve listening) and preferably next to a role model

**Intervention strategy for completion of Assignments:**

- Allow extra time to complete assignments.
• Shorten the assignment time to coincide with time of attention; gradually lengthen the sessions.
• Give assignments one at a time to avoid overload.
• Cue students to stay on a task.
• Give clear, concise instructions.
• Written instructions along with oral instructions help, as children with ADHD have difficulty in recalling what they have heard.
• Include elements in which self-reminder can also help to improve listening skills, e.g., “mustn’t talk when listening.”

Intervention strategy for Impulsiveness
• Ignore minor, inappropriate behavior.
• Attend to positive behavior with praise. Social praise helps the child to develop good self-esteem and also increases the frequency of positive behavior.
• Set up behavior contracts and encourage self-monitoring of behavior.

Intervention strategy for Motor activity
• Allow the child to stand at time while working.
• Set goals for maintenance of proper posture and encourage self-monitoring. Cueing also helps.
• Provide opportunity for movement, i.e., running errands, distributing, and collecting books etc.
• Provide short breaks.
• Supervise during transition times

Organization/planning
• Send weekly/daily progress reports home. Seek parental help in facilitating organization skills.
• Supervise writing down homework.
• Encourage and reward neatness rather than penalize sloppiness.
• Help students set short-term goals.
• Do not penalize for handwriting, if visual-motor difficulties are present.

SOCIALIZATION

Structure:
External order compensates for internal chaos. Establish routine especially at potential high-stress times like breaks, lunch times, games period and after-school hours. Visual and written instructions could be used as reminders.

Supervision:
During any activity, check periodically to make sure the child is progressing correctly. Deal with problems while they are still manageable. Rules should be placed in positive terms, i.e., instead of saying “Don’t grab”, say “Request if you want something”. Be specific in direction. Instead of saying “Don’t run around, “say “Please come back to you seat,” etc.

Support
To ensure continued success, provide instructions on any changes needed next time and offer encouragement. Children with ADHD possess a lot of desirable traits. A teacher should also focus on the positive traits and use them to facilitate the child to cope better. Some of these traits include the following:
• Creative
• Spontaneous
• Energetic
• Accepting and forgiving
• Inquisitive and imaginative
• Innovative
• Resourceful
• Gregarious
• Resilient

Understanding and respecting differences and responding to children, based on their learning styles, open up a new vista for the child, in fact for all children and not only for children with special needs. Every child has the potential and motivation to learn. The teacher should realize this fact and plan teaching and evaluation strategies to suit the needs of the child.
DISRUPTIVE BEHAVIOUR DISORDER

Disruptive behaviour disorders include four clusters of behaviour problems. They are:

- Conduct Disorder
- Personality Disorder
- Immaturity
- Socialized Delinquency

Behaviour disorders also can be described in terms of severity. Most behaviour disordered children have moderate problems that can be treated effectively in the regular classroom and a home. Severely disturbed children—often called psychotic, schizophrenic or autistic—require intensive programming, usually in a more restrictive setting.

Characteristics:

- Many of them are ‘slow learners’ or ‘mildly retarded’ with a score of about 90 on an IQ test. Autistics are most of the time untestable.

- Aggression and acting out often with little or no provocation are the most common characteristic. Such noxious behaviour includes disapproval of others, negativism, non-compliance, yelling, teasing, attacking self or others, whining etc.

- Withdrawn behaviour and apparent lack of social skills displaying lack of sensory response, self stimulation, echolalic or psychotic speech, self-mutilating behaviour, tantrums and behaviour deficiencies.

Causes of Disruptive Behaviour Disorder:

- Possible biological causes more evident in severely and profoundly disturbed children. Many autistic children show neuro-chemical imbalance and genetics often seem to play a role in childhood schizophrenia.

- Psychological factors like parent-child relationship and interaction, undesirable school experiences, inappropriate expectations, cruelty from others, unfair treatment may result in disruptive behavioural disorders.

Identification and Assessment:
There no reliable method for sure identification of emotional disturbance. Psychological tests and interviews have limited practical value.

- While aggressive students stand out, withdrawn may go unnoticed.

- Screening tests for identifying disturbed students are being developed.

- Direct and continuous observation and measurement of specific problem behaviours, within the classroom, is becoming more and more popular. It is an assessment technique that indicated directly what intervention is needed.

**Educational Strategies for Disruptive Behaviour Disorder:**

- **Psychodynamic Approach**- This approach relies on psychotherapy and creative projects for the child rather than academic remediation. Emotional disturbance is thought of as a psychopathological process.

- **Biological Approach**- It suggests that the deviant behaviour is a physical disorder with genetic or medical causes implying treatment of emotional disturbance.

- **Behavioural approach**- This approach assumes that the child has learned disordered behaviour and has not learnt appropriate responses. To treat the problem, the teacher uses behaviour modification techniques.

- **Ecological Approach**- This approach suggest that the interaction of the child with the people around him and with social institutions. Treatment involves teaching the child to function within the family, school, neighbourhood, and larger community.

- **Humanistic Approach**- This approach suggest that ‘the disturbed child is out of touch with his own feelings and cannot find self fulfilment in traditional educational setting. Treatment takes place in an open, personalized setting, where the teacher serves as resource or catalyst.

- **Self management technique where the teacher plays very significant role by teaching the child self- control and or self-management skills couples with social skills is a unique approach to deal with such disturbed children. It implies a combination of professional competencies and**
personal characteristics to be an effective teacher for these students.

5.2d INCLUSIVE EDUCATION

i) Concept of Mainstreaming, Integration and Inclusion

ii) Need and Importance of Inclusive Education in the Indian Context

The traditional approaches to Special education of the exceptional children had many disadvantages like depletion of resources as a result of duplication of efforts, labelling and the minority status attached to this group of students damaging their self concept further and more importantly, leading to 'social isolation', thereby defeating the very objective of special education.

MAINSREAMING

Mainstreaming appeared as an alternative to traditional approaches to overcome the above mentioned disadvantages. Mainstreaming is an educational approach designed to end the segregation of exceptional children by keeping these children in the mainstream of educational system and providing them with a broad range of educational alternatives. According to Stephens and Blackhurst, “Mainstreaming is the education of the mildly handicapped children in the regular classroom. It is based on the philosophy equal opportunity that is implemented through individual planning to promote appropriate learning, achievement and social normalization.”

INTEGRATION

The very term ‘integration’ signifies the process of interaction of disabled children and normal children in the same educational setting. Integrated education is an educational programme in which exceptional children attend classes with normal children on either full time or part time basis. Such a combination may be taken as social integration or academic integration. It is a broader concept which includes ‘mainstreaming’. The difference between the two terms is quite subtle. In mainstreaming, the normal school is letting the exceptional child be part of it. In integration, the normal school is the rightful place for the exceptional child to be in, learn and grow. But still the onus of adapting to the school environment lies largely with the exceptional child.
INCLUSIVE EDUCATION

Inclusive education is concerned with removing all barriers to learning, and with participation of all learners vulnerable to exclusion and marginalization. It is a strategic approach designed to facilitate learning success for all children. It addresses the common goals of decreasing and overcoming all exclusion from the human right to education, at least at the elementary level, and enhancing access, participation and learning, success in quality basic education for all. (Education for all 2000 Bulletin, UNESCO, No.32, 1998).

The main elements of inclusive education are:

- A human rights issue (“Education for ALL children, not almost all).
- Education of All in a School for All (disabled and non-disabled children learning together in regular schools: learning to know, learning to do, learning to be and learning to live together).
- Togetherness (enabling all to participate together in society from the beginning, contributing to social harmony and stimulating the building of relationships among individuals, groups and nations).
- Breaking barriers (familiarity and tolerance reduce fear, prejudices and rejection).

Inclusion can be realised by:

1. Removing physical barriers posed by stairs, doorways, toilets, water faucets, and other architectural aspects imperative to accessing facilities in the school.

2. Removing the barriers of the teaching system, by providing facilities for accessing information related to the curriculum, by the use of modern technology like computers using specialized software and by providing awareness, sensitivity and solutions for teachers.

3. Removing the barriers of the examination system by providing means of free and fair evaluation of the students’ knowledge irrespective of his/her sensory/physical status.

4. Removing the barriers of attitude developed due to lack of awareness.
Thus, it is evident that inclusion encompasses the two concepts discussed earlier, namely, ‘mainstreaming’ and ‘integration’ and goes a step further by not only opening its doors for ALL, but also with a promise to reinvent itself to accommodate them all with their special needs and requirements.

**NEED AND IMPORTANCE OF INCLUSIVE EDUCATION IN THE INDIAN CONTEXT**

India is a country with abundant human capital. This important human resource should be tended properly through education and training to engage it successfully in the nation building activity. But unfortunately more than half of our youths are out of the school system due to various reasons. This is in violation to Human Rights issue which stresses upon upholding human dignity. The main goal of Right to Education Act is make education available to each child irrespective of his location, class, cast, religion, status and standing mental and physical limitations and other disadvantages the child may be suffering from. Investment in education to include all is the set goal before the country and as such, there are number of initiatives taken in pursuance of this objective. They are as following:

**National Initiatives**

1. **The Indian Education Commission (1964-66):** The Indian Education Commission was the first statutory body to suggest that the education of handicapped children has to be organized not merely on humanitarian ground, but also on grounds of utility. The Commission observed that although the Indian Constitution had issued specific directives about compulsory education for all, including children with disabilities, very little had been done in this regard. The Commission also emphasized that the education of children with disabilities should be “an inseparable part of the general education system”. At the time when the Commission made its recommendations there were less than 250 special schools in India. The commission felt that services for children with disabilities were extremely inadequate and recommended the adoption of a dual approach, namely, the provision of special as well as integrated education to improve the situation. The commission set the following targets to be achieved by 1986: education for about 15
percent of the blind, the deaf and orthopedically handicapped and 5 percent of the mentally retarded. The Commission also specifically emphasized the importance of integrated education in meeting this target as it is cost-effective and useful in developing mutual understanding between children with and without disabilities.

2. **Integrated education for Disabled Children (IEDC, 1974):**
In 1974, the Ministry of Social Justice and Empowerment, Government of India, initiated the IEDC program to promote the integration of students with mild to moderate disabilities into regular schools. Children were to be provided financial support for books, stationery, school uniforms, transport, special equipment and aides. The state governments were provided 50 percent financial assistance to implement this program in regular schools. However, the program met with little success. A criticism of this program in the state of Maharashtra reported that the (a) non-availability of trained and experienced teachers; (b) lack of orientation among schools staff on the problems educational materials, were the major contributory factors for its failure. A lack of coordination amount various department to implement the scheme was also considered a major contributor for its failure. By 1979-80, only 1,881 children from 81 schools all over the country had benefited from this program. Due to the failure of the IEDC scheme, it was revised in 1992. Until 1990, the scheme was implemented in 14 states. These were Andaman and Nicobar, Bihar, Gujarat, Haryana, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Nagaland, Orissa, Rajasthan, Tamil Nadu and Uttar Pradesh. Kerala is the only state that has shown remarkable progress in implementing this scheme. In Kerala, the scheme has been implemented in 4,487 schools and 12,961 children have been served under this scheme.

3. **National Policy on Education (NPE, 1986-92):** In 1968, the Indian Government formulated the National Policy on Education for all government schools and articulated a need to integrate students with disabilities. Again in 1986, the National Policy on Education devoted a specific section to the education of students with disabilities. It emphasized that whenever feasible, the education of children with motor handicaps and other mild disabilities should be provided in regular schools. The National Policy also stressed that those children whose needs could not be met in regular schools...
were to be enrolled in special schools. Children who were already in special schools could be integrated into regular schools as soon as they acquired reasonable levels of daily living, communication and basic academic skill. It also emphasized the need to restructure primary teacher training programs to prepare teachers to deal with the special difficulties of children with disabilities.

4. **Project Integrated Education for the Disabled (PIED, 1987):** In 1987, the Ministry of Human Resource Development (MHRD) in association with UNICEF and the National Council for Educational Research and Training (NCERT) undertook “Project Integrated Education for the Disabled” (PIED). The aim of the project was to strengthen the implementation of the IEDC scheme.

5. **District Primary Education Program (DPEP, 1994):** A centrally sponsored scheme, the District Primary Education Program aims to reduce the overall dropout rates of all students enrolled in primary classes, to raise their achievement levels and to provide primary education for all children, including children with disabilities. This is probably the largest program of the central government in terms of funding.

6. **The Persons with Disabilities Act (PWD Act, 1995):** A close examination of the national initiatives discussed so far indicates that although the Indian Government had made several attempts to implement integrated education programs, it lacked a firm commitment to promote integration. This was largely because the Indian Government has considered provision for children with disabilities to be a welfare issue rather than an educational imperative. The PWD Act proposed the provision of improved educational services, medical care, vocation training, employment, and social security for all persons with disabilities. The Act further stated that whenever possible, students with disabilities should be educated in regular school settings.

**Challenges ahead for Inclusion**

The above mentioned policy statements made under different commissions highlight the importance government attaches to ‘education’ and then ‘education for all’.
The current practice of focusing solely on the 3Rs approach has led to education being viewed not as a process, but as a product—the tangible reward consisting of a report, marks sheet, or degree at the end. When children fail to learn in school it is only too tempting to perceive something wrong within them. Educational activity is one of the many social entities that cannot be examined in isolation. Schooling interconnects with a more extensive and complex reality, reflecting continual changes and transformations with unpredictable outcomes. The character of school activity is not only a mirror of aspects of contemporary modes of production, but also the dominant economic priorities and political activities in society. Many have voiced fears that within this climate it is unlikely that schools will give priority to inclusive values and principles.

**How can the Schools Respond?**

Recognition and respect of all children have to be at the forefront while planning schools if inequalities are to be tackled. Maria Montessori, an educator far ahead of her time, in one of her lectures in India had said: “the world of education is like an island where people, cut-off from the world, are prepared for life by exclusion from it”. For inclusion to move from mere rhetoric, the disadvantaged and marginalized groups of students must not only have access to opportunities and share the same space, but also like their peers, must share the common wealth of the school and its culture. Inclusion means inviting those who have been historically been locked out to “come in”. Schools have to change from mere “teaching shops” to inculcating a broader change in their social climate and the way “differences” and “difficulty” is conceptualized in order to foster a “just society”. Responses to differences vary amongst communities and indeed within communities come. So, what is equality? “Equality” “sameness” and “difference” do not lie on a continuum, but are the three corners of a triangle. The notion of “equality in difference” is then to treat people as equals but not necessarily the same way. Therefore, it is imperative that schools must recognize a continuum of diverse needs amongst all children and utilize all its available resources to make appropriate provisions to meet their needs. Inclusion does not necessitate denying differences amongst people, rather, every civilized nation must strive to reduce inequalities which arise from its own structure. Ideal inclusion exists when schools work towards reducing inequalities, which arise from birth or circumstances, rather
than exaggerate them. This notion of ideal inclusion therefore does not set boundaries around particular kinds of supposed disabilities. Rather, it provides a framework within which all children, regardless of ability, gender, language, ethnic or cultural origin are accepted equally at school. Ideal inclusion thus proposes a far broader yet more distinct a meaning, moving from what is called an “obsession with individual learning difficulties,” to an agenda of finding solutions.

**Ideal Inclusion: Building Bridges**

This emphasis of meeting the challenge of the ideal school inclusion will result in making educational and social sense to all those students who drop out of schools, repeat classes, live on the streets, come from disadvantaged homes or remote tribal areas, are members of ethnic linguistic minorities, child labourers or face gender discrimination. This involves a serious commitment to the task of identifying, challenging, and contributing to the removal of education systems as they are designed today-based on homogenous delivery rather than diversity. Removing exclusion in and from education is part of the process of reducing exclusion in society. Constantly challenging inequalities of power and recognizing and removing the oppression faced by a large number of excluded children can only realize this. Mahatma Gandhi had advised many decades ago, that education must become co-existent with life. Education, as it is conceived today, is estranged from social life. Interestingly, the imperative to address the issue of inclusion has been spearheaded by the need to address the value of those students, who were believed to have the least worth for many centuries.

### 5.3 LET US SUM UP

To quote Charles Darwin: “it is not the strongest of species that survive, not the most intelligent, but the one most responsive to change”. Education must therefore reinvent the reconstruct itself so that to be “built to last” is actually “built to change.” The goal of developing schools as caring communities for all students may seem a distant dream; but then are not the fantasies of yesterday, the realization of today!

### 5.3 UNIT END EXERCISE:
1. Whom do we consider as exceptional children? How would you classify them?

2. Describe different groups of cognitively exceptional children. Explain the strategies before the classroom teacher to deal with them.

3. Explain the characteristics of the physically exceptional children. Discuss the problems faced by this student group.

4. “Socio-culturally disadvantaged children need special attention and educational input.” Discuss.

5. What is a learning disability? How do you deal with a dyslexic child?

6. What do you understand by the terms ‘dysgraphia’ and ‘dyscalculia’? Describe any two activities that you can plan for helping out these students.

7. Discuss in detail ADHD and remedial measure the teacher can plan to deal with these students.


9. Elaborate the need for Inclusive Education in Indian context.

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