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Abstract

This article describes the disorder of autism in the spectrum of pervasive developmental disorders, the challenges that the autistic child faces, and the inclusion of an autistic child, a nine-year old boy, into a self-contained third grade classroom. Through details of his life, the reader is given an intimate look at the personal and educational issues he faces as he struggles to cope with his disability. In addition to focusing on how the disorder affects an individual, the paper stresses the importance of parents and professionals working together to develop and implement teaching strategies that will assist such a child in living a successful and productive life.

Inclusion of an Autistic Child
into a
Self-Contained Third Grade Classroom

A Journal Article
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by
Arlene M. Belt

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Abstract

This article describes the disorder of autism in the spectrum of pervasive developmental disorders, the challenges that the autistic child faces, and the inclusion of an autistic child, a nine-year old boy, into a self-contained third grade classroom. Through details of his life, the reader is given an intimate look at the personal and educational issues he faces as he struggles to cope with his disability. In addition to focusing on how the disorder affects an individual, the paper stresses the importance of parents and professionals working together to develop and implement teaching strategies that will assist such a child in living a successful and productive life.

The term "pervasive developmental disorders" (PDDs) refers to a group of severe and pervasive conditions that begin in infancy or early childhood and have an impact on several areas of development including socialization and language (Glasberg, Harris, & Ricca, 1996). A child diagnosed with a PDD will present a unique array of problems that are perplexing because his or her responses will often seem so inconsistent with what is understood about human learning and behavior (Quill, 1995).

Autism is classified as one of the pervasive developmental disorders. First described and named by Leo Kanner in 1944, this mysterious disability is characterized by emotional and intellectual detachment from others. In autistic children, an impaired capacity for communication and human relationships and a severely restricted range of activities and interests become evident before the age of three (The Harvard Mental Health Letter, 1997).

Autism and its associated behaviors occur in approximately 15 of every 10,000 individuals and is four times more prevalent in boys than girls. It knows no racial, ethnic or social boundaries. Family income, lifestyle, and educational levels do not affect the chance of autism's occurrence. It is often referred to as a spectrum disorder: Symptoms present themselves in a wide variety of combinations from mild to severe. Although autism is defined by a certain set of behaviors, children and

adults can exhibit any combination of these behaviors in any degree of severity (Dorman & Johnson, 1996). Because it varies widely in its severity and symptoms, autism can go unrecognized, especially in mildly affected individuals or in those with multiple handicaps (Autism Fact Sheet, 1995). It is also a disorder that is frequently misdiagnosed. Studies from the last five years have shown that many people who engage in autistic behaviors have related but distinct disorders. These include Asperger's Syndrome, Fragile X Syndrome, Rett Syndrome, and William's Syndrome (Edelson, 1995). These subtypes need to be considered in order to make an accurate diagnosis of the disorder.

Educational Opportunities for Children with Disabilities

Under the federal law, the Individuals with Disabilities Act (IDEA), children with autism and other developmental disorders are eligible for educational opportunities appropriate to their needs from the age of three. The law requires an evaluation and an individual education plan (IEP) with a reevaluation at least once every three years. Depending on the child's need, there is a wide variety of educational arrangements, from mainstreaming and regular classroom placement for the most capable children to private residential programs for the most severely affected (The Harvard Mental Health Letter, 1997). In the case of autism, a growing need is seen to bridge

the gap between research and practice in the area of educational intervention. It is necessary to weave the understanding of the atypical developmental profiles and the unique learning patterns of children with autism in order to fully address their educational needs (Quill, 1995).

Children with autism will usually display developmental patterns that seem to follow a different path from the generally expected. Teachers may need assistance in understanding how these disorders have an impact on a child's social and cognitive repertoires as well as on the domain of behavior management. Although these children have severe learning problems, they can be taught by skilled teachers using special teaching methods (Glasberg, Harris, & Ricca, 1996).

One aim of teaching a child with autism should be to help them find some way to cope with their difficulties, just as blind children are taught to read with Braille and those with paralyzed legs are taught to strengthen their shoulder and arm muscles. Another aim is to help these children become acceptable members of society so that they can live at home with their own families, or perhaps independently in adult life. A third aim is to teach them the skills necessary for earning a living, in open employment if possible, or in a sheltered environment (Wing, 1991).

While there is no cure for autism, collaborative interventions of parents, professionals, and paraprofessionals can make a significant difference (Edelson, 1995). A generation ago, 90% of people with autism were eventually placed in institutions. Today, as a result of appropriate and individualized services and programs, even the most severely disabled can be taught skills that allow them to develop to their fullest potential (Dorman & Johnson, 1996).

Family Life and Autistic Children

Having a child with autism can present parents with unique family-life challenges. Parents need to consider the impact a child with a disability can pose for a family: Parents have to consider the effect the disorder has on the siblings in the family. Many children with autism require such specific attention that siblings may feel excluded or alienated within the family. A strong possibility may exist that more than one member of the family may have the disorder. Studies have shown a genetic influence related to autism. For example, there is a greater likelihood that two identical twins will have autism than two fraternal twins. In the case of identical twins, there is a 100% overlap of the genes; whereas in fraternal twins as in non-twin siblings, there is a 50% overlap in genes. In addition, many apparently normal parents of autistic children have undiagnosed mild autistic symptoms (Edelson, 1995).

Parents often face social ridicule and rejection by others and are frequently judged negatively as the result of their child's condition. Children with autism, for example, look normal, thus other people often do not understand why the child screams or behaves badly in public. Parents can receive critical responses instead of empathy and help. The lack of ability to control a child's behavior is viewed by many as inadequate parenting (Wing, 1991).

The difficulty of raising a child with autism puts an extreme amount of pressure on the relationship between the parents. They often feel guilty and blame themselves or each other. They search for reasons why it has happened to their child and for solutions to the problem. Parents often feel alone and do not understand the cause of the condition and how to cope with it. Even though they love their child and have done their best for him or her, they seldom feel like they have done enough. Many parents worry about what will happen when they are no longer able to care for their child (Wing, 1991).

It is these factors, in addition to a number of others, that inevitably cause emotional stress and conflict for all of those involved. Yet, many parents struggle on, either individually or as a team, in anticipation of seeing growth in their child. When progress does come, the happiness each small

achievement brings seems many times greater than the rapid progress made by a typical child (Wing, 1991).

The Case of an Autistic Child Placed in a Self-Contained Classroom

Jared's Early Years

Jared is 9 years old. Even though he is diagnosed as autistic, he has full inclusion in my third grade class. The rest of my article deals with his case history and his present educational program.

Jared's mother had a normal pregnancy and delivery. She did not drink and had never smoked or used drugs. Jared was born without the use of instruments. During the first six months of his life, Jared was very difficult to handle. He was what most people refer to as a "holy terror." He was very active, crying and screaming continuously for no apparent reason and would go for many hours without sleeping. He accepted little nourishment but Enfamil, a ready-to-use formula, and apple juice. Even though his parents blamed his discontent on colic and teething, all along they felt something else was wrong.

An unexplained characteristic of Jared which seemed incredible to his parents was his total lack of reaction to noise. The family owned three dogs, which barked constantly. Jared seemed to totally disregard their racket. One day while Jared was lying on a blanket on the floor, the dogs knocked over

a table and lamp. The lamp landed just inches from Jared's head causing a terrible noise to which Jared made no response. Because his parents were concerned about Jared's lack of response to the noise in his environment, they took him to have his hearing checked. The specialists concluded that his hearing was normal.

As Jared grew, his behaviors became worse: He was impatient, very demanding, short-tempered at times and would become easily frustrated. He would scream, bite, and pinch his parents when he became upset. He did not tolerate separation from his parents and avoided contact with others. His speech development was inconsistent and abnormal. While he did babble and use jargon, he did not use words to communicate. His feeding skills were poor; he was very selective about the foods he ate. He generally refused solid food, usually tolerating baby food.

His parents also had concerns about Jared's extreme fascination and unique use of particular objects. Although he seemed obsessed with collecting cars and toys, he did not play with them. He spent a great deal of time looking through magazines, pointing at pictures, and highlighting various words with a marker. He also used calculators to add up either the amounts he found in magazines or grocery items he would see while he was at a store with his mother. He used calculators so much that the numbers on the buttons quickly wore off.

Assessment of Jared's Disorder

When Jared was two years old, his parents took him to a national research center to have a speech and language and psychological evaluation. The conclusion of the evaluation indicated that while Jared's hearing was normal, he was developmentally delayed and behaviorally disturbed.

Recommendations for Jared included remedial services at school, speech and language services, continued language stimulation from his parents at home, and consultation from a feeding specialist. A psychologist discussed with Jared's parents the possibility that they were creating his behavior by being too permissive with him. They were advised to set limits and guidelines for Jared and to follow through with a time-out procedure when Jared refused to comply. It was also suggested that Jared be placed in a toddler group so he could benefit from exposure to appropriate peer interactions.

His parents attempted to carry out the recommendations from Jared's assessment at the research center, but his behavioral disorders became more severe. He was enrolled in a toddler group for peer interaction, but it proved to be disastrous. He refused to interact with others, would lie on the floor, and move away from the group if others attempted to interact with him. He continued to have extreme separation anxiety, crying and screaming for long periods of time when his mother left him. His

infrequent use of language consisted of spoken words which were not directed to interacting with others. He would express his needs by pointing to or taking his parents to whatever it was that he wanted. Although Jared had been diagnosed as mentally retarded, his parents still believed that there was another cause for his problems. Based on their personal experience from working at a facility for the physically and mentally handicapped, they were convinced that Jared's problems were misdiagnosed. His parents continued to search for answers to his behavioral problems.

When Jared was three years of age, his parents took him to be examined by a neurologist. It was then that a PDD diagnosis was made. His parents felt both relief and despair. Finally, they were given a diagnosis they could understand. However, they were told that there was no hope for Jared and that if he remained in the home, he would destroy the family unit and any chance for a normal life for his younger brother, Joey. His parents were advised to place Jared on medication and admit him to a facility where he would receive proper care.

Jared's parents sought a second opinion before initiating the recommendations of the neurologist. He was taken to another team of specialists for an assessment. It was the team's consensus that Jared was exhibiting several behaviors typically associated with autistic children. His parents were given

suggestions of services available to them that included counseling, support groups, and services from the Area Education Agency (AEA) Autistic Team to assist in program planning.

Jared's Response to His School Environment

Based on the second assessment, Jared qualified for special education services. He attended a preschool program from September of 1991 until May of 1994. Entering school was a big adjustment for Jared. The biggest challenge in entering this new environment was learning to feel safe within it. He cried, refused to participate, and was difficult to redirect. By the end of preschool, Jared had made great progress. In the school environment, he appeared happier, would initiate an activity or task without the aid of an adult, and would work for longer periods of time without prompting. He was also learning how to make choices for himself, respect guidelines, and accept transition times.

Since kindergarten, Jared has attended regular classes in a public school. He has continued to receive direct assistance from a special education teacher in the following areas: peer interaction skills, transition skills, impulse control, appropriate ways to gain teacher attention, and attention to task. He has received speech-language therapy since 1991 and occupational therapy since 1994.

During the past three years, Jared has made impressive growth academically and behaviorally. Because of his limited writing ability, he uses a computer. Currently, he is relying on it less and is using it to complete less than half of his written work. He demonstrates above grade level academic skills, especially in the areas of reading and spelling. He also has extended interest and knowledge in the areas of science and medicine.

Jared has shown significant improvement in his awareness of others. He has become more sociable and is establishing friendships. He is also cooperative, respectful of others, well-behaved and seeks to please adults. He is more adaptable and flexible to changes and is able to express his feelings more easily. He needs to improve in these areas: slowing down and checking his work, developing risk-taking behaviors, understanding and accepting his errors, and requesting help from adults and peers in an appropriate manner.

In teaching children with disabilities it's important for a teacher not to feel isolated in the instructional process. A teacher needs to be a part of a team. Before Jared entered my classroom, I had the opportunity to meet with him, his mother, and others who were working with him. The staff who have worked with Jared were generous about sharing information and strategies that have been beneficial to him. His mother has also been

supportive of my efforts with him. She has supplied me with information pertaining to his diagnosis. She communicates with me on a daily basis and actively supports her son's growth.

As Jared's third grade teacher, I needed to become informed of autism in order to relate effectively to him and to plan an instructional program that was meaningful to him. As the year progressed, I discovered that while Jared has specific social and learning needs, he has much in common with children of his age. He is a gentle child who wants to know why things have to be done in a certain way. He needs reminders of how things should be done, has learned about limits and acceptance, and most of all, about being flexible. The most effective instructional strategies that I use with Jared are modeling and role-playing. On the playground, I persuade Jared to trust me to hold the medical book that he carries with him while he participates in a game. For some situations that arise, we act out appropriate actions and responses. My goal for Jared's educational experience has been to turn as many situations as possible into learning experiences for him so that he might strengthen the skills he will need to be successful in his life.

Jared has recently been diagnosed with Asperger Syndrome which is the term applied to the mildest and highest functioning type of autism. Asperger Syndrome (AS) is a term used when a child or adult has some of the features of autism but may not

have the full blown clinical picture. A few people with AS are very successful and until recently were not diagnosed with anything but were seen as brilliant, eccentric, absent minded, socially inept, and a little awkward physically (Cook, 1998). AS was first described by a German doctor, Hans Asperger, in 1944 (one year after Leo Kanner's first paper on autism). In his description, Dr. Asperger discusses individuals who exhibit many odd behaviors within three areas; language, cognitive, and behavior. People with AS have speech that is sometimes repetitive and their voices may be flat without emotion. They may have intelligence levels that fall along the full spectrum but are more than likely above the normal range, are concrete thinkers, and may be referred to as eccentric. Their gross and fine motor skills may be poor: they may appear to be clumsy and awkward and have unique forms of self-stimulatory behavior (Edelson, 1995).

One characteristic that is specific to AS and not found in the typical responses of autistic children is in the area of socialization. Although children with AS are noted by parents and teachers to be somewhat in their own world, they are seldom as aloof as children with autism. They do have friends and can be taught to interact socially, but they are often unaware of others' needs and perspectives and unable to respond to them appropriately.

Another differing characteristic of AS is how these children use language. They may have difficulty sustaining the "give and take" in conversations, taking turns, responding to what others have said, and understanding humor, jokes, or puns.

The most obvious hallmark of AS and the characteristic that makes these individuals so unique and fascinating is their peculiar areas of "special interests." In contrast to more typical autism where interests are likely to be objects or parts of objects, in AS the interests appear most often to be specific intellectual areas. In many instances these areas of interest will change over time, with one preoccupation replaced by another. In some cases these childhood fascinations persist into adulthood and even have formed the basis for an adult career. Studies suggest that compared to other forms of autism, children with AS are much more likely to grow up to be independently functioning adults in terms of employment, marriage, and family (Bauer).

Conclusions

Children with the distinct disorder of autism or autistic-related disorders can usually function within a school setting. Early intervention and continual treatment is vital for any child with autism. Personal-social development and success in school for the autistic child can be complex and not achieved through simple remedies. It is important for the educational

staff and other support personnel to have a clear understanding of each child's particular response to the learning environment and to plan appropriate instructional strategies as a team that includes the home caregivers.

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