
SEE/HEAR

A QUARTERLY NEWSLETTER ABOUT VISUAL IMPAIRMENTS
AND DEAFBLINDNESS FOR FAMILIES AND PROFESSIONALS
A collaborative effort of the Texas School for the Blind and Visually Impaired
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Kate's Corner

If you are receiving this newsletter, congratulations! You are one of the approximately 1,900 individuals who remembered to send in your update for our new mailing list database. We are pleased that you took the time to send it in, and we think this new database will be much more accurate than our previous one. However, our old mailing list had over 7,000 addresses. Now, we know that many of those were old addresses, and we know that some people no longer wish to receive SEE/HEAR for one reason or another. We also think that many people who did want to continue getting the newsletter didn't get an updated form mailed to us. Since you did, we need your help.

If you are a teacher, caseworker, or other professional working with families of children with visual impairments or deafblindness, please check with those families and ask them if they received this newsletter. Also, check with your colleagues who would like to or normally receive the newsletter. If they didn't get a newsletter this time around and would like to receive it in the future, please share with them a copy of the form included in this newsletter, or on the TSBVI website.

If you are a parent of a child with visual impairments or deafblindness, check with other parents or your child's professionals to see if they received this edition of the newsletter. If they didn't and would like to start or continue to receive it, have them call us at (512) 206-9103, visit the website, or make a copy of the form included with this newsletter

You are in for a real treat this month. The Spring 2000 SEE/HEAR has many wonderful articles. I would like to take a minute to say thanks to the SEE/HEAR Section Editors, Jean Robinson, Gigi Newton, Ann Rash, Jenny Lace, and Jim Durkel. Also, thanks to Edgenie Lindquist our TCB Consultant, Craig Axelrod our Layout Editor, Jesse J. Garcia, our Production Editor and Cyral Miller who is the best proofreader I know. Without their efforts and the efforts of Jim Allan who makes the newsletter available on the web, Recording for the Blind and Dyslexic, which records this on audiocassette and Ann Hill at TCB who does our braille edition, this newsletter literally wouldn't happen. I appreciate you more than you know, and so do all the readers of SEE/HEAR.

Franky's Story

By Connie Vasquez, Parent, McAllen, Texas

Editor's note: Each time I hear a family's story I learn more about the gifts of life. I think it is important that we share these stories with, not only other parents of children with disabilities, but also teachers, doctors, legislators and community members. Those of us who are professionals in the field of special education sometimes forget that the general public has little, if any, experience with disabilities. To them the world of disabilities and chronic illness is a foreign, scary place. They need to understand that it does not need to be. Children with disabilities and their families can have better lives if we care enough to hear them and provide the support they need.

We were living in McAllen, Texas, when we found out I was pregnant with our first child. Like most first time parents, we were excited and a little nervous. The pregnancy seemed to go by normally. I had the usual miseries, and I got a virus I couldn't seem to shake about the third month. I didn't even mention it to the doctor. I figured the extreme fatigue was just a result of pregnancy, and the chronic sore throat was just allergies.

I prayed that there would be nothing wrong with the baby. We had all of the usual tests and ultrasounds and everything seemed normal. Yet something told me that something was wrong. I guess it is that sixth sense we sometime get.

On April 15, 1993, Franky was born after a normal labor and delivery at 38 weeks. When he was brought to me, I was surprised at how hard it was to change his little shirt; his arms were so stiff. I chalked it up to inexperience. The next day my doctor came in to tell me that Franky's head was too small for his body. She was hoping that the bones in his skull had fused together and that an operation might separate them. I thought to myself, if this is the best-case scenario, what could be the worst?

After a MRI was done, the neonatologist came in to see me. He told me that there was brain damage and they didn't know what problems Franky would have. He mentioned epilepsy, cerebral palsy, blindness, deafness, etc. He said that we would have to wait and see. He also told me that it wasn't fair for him to have to break the news to me, since he didn't know me. I guess he thought it was fair for me to hear the news!

Of course, I spent a lot of time crying. I had to break the news to my husband when he came. I wish he could have been there when they told the news to me, but I guess the doctors never thought of that. The nurse saw me crying and told the hospital's psychologist. She came to see me, and asked what was wrong. When I told her, she just told me to call if I needed anything. There was no sympathy, and she never came back to check on me. I guess she wasn't qualified for real problems.

Just as I was to be released, another neonatologist came in to see me. He very callously told me that my son would never be anything but a vegetable and would never know us. He advised us to take him home and wait for him to die. He said that Franky would probably die in his sleep of SIDS. He added that we needed to come by his office the next day to give him our decision as to what we would do when we found him dead. He also told us that Franky had a urinary tract infection and would need to stay in the hospital for 7 to 10 days. I asked to see him before I was discharged. He told me that was impossible because Franky already had been transferred to an intermediate neonatal nursery. I was naive enough not to fight him.

During this time, the only comfort we received was from my personal physician, Dr. Bertha Medina. After the neonatologist left, she started crying. She told us that her first child had died from a brain defect. She cried with us; then gave us some advice that we have never forgotten. She told us that this crisis would either make or break our marriage, and we had to make sure that it brought us closer together.

We found out that the CMV virus, which I had never heard of until then, presumably caused the brain damage. It most likely happened when I felt so sick at the end of the first trimester. No one caused it, and no one could have prevented it. Even if we had known I had the virus, the doctor could not have done anything but suggest an abortion, which we are completely against. All it would have done was make us dread his birth. I am glad we did not know until after he was born, but relieved that we found out right away.

Over the next few days we broke the news to our family and friends. My mother-in-law, who came to help me said, "He is family, and we love him no matter what problems he may have." We got lots of moral support from our church even though we had been members for only a short period of time. We got mixed reactions from our friends. Some were sympathetic and caring; some were indifferent. Others felt like somebody was to blame even though there was no evidence of it. They said

that the doctor had to have done something wrong. One of my closest friends even suggested that it was my fault. We found out who our true friends were.

We found out that the stiffness and difficulty in dressing Franky was due to cerebral palsy. When he was three months old, we found out he was blind except for a little peripheral vision. He is deaf in one ear, but the other ear is fine. He has profound mental retardation.

When Franky was about six weeks old, he started screaming day and night. We thought it was colic, but it didn't go away. When he was nine months old, he had his first visit with a neurologist. He told us that the screaming was normal for a child in Franky's condition and recommended trying Klonopin to calm him. We hesitated to drug him as he had just started smiling, but we decided to try it for a few days. After a trial period, the only complaint we had was why didn't someone prescribe it before? One of his therapists was opposed to this drug therapy, but she didn't have to live with him day and night. He became a happy child. He began to laugh at every little noise. Our lives changed overnight.

Franky's muscle tone is extremely tight, and the cerebral palsy affects every part of his body. We would spend all day trying to feed him. When he was three years old, we made the difficult decision to give him a feeding tube. We didn't want to take the easy way out. Although it did make feeding a lot easier, Franky developed severe reflux. Every time he gets a cold, he gets a vicious cycle of congestion, coughing, and reflux, which causes more coughing and more reflux. Now we have found that reflux itself causes congestion.

Franky has a neurogenic bladder; so I have learned to catheterize him. I have also learned to suction him, change his feeding tube and do all kinds of things I never expected to do. Sometimes I feel like a doctor. Franky takes eleven medications every day for reflux, muscle relaxation, bladder spasms, asthma, seizures, etc. When he is sick, he takes even more. Last year I filled more than two hundred prescriptions for him in a twelve-month period.

Now that Franky is seven years old we thought that the threat of SIDS had gone away. This year we found out that it has actually gotten worse. A sleep study showed that he has severe apnea. His chin is receded and his palate extends way back into his throat, which narrows his airway considerably. If he isn't in just the right position, he will stop breathing, even when he is awake. He has an expensive

wheelchair that he is unable to use. We have never been able to adjust it to a position that doesn't restrict his breathing. We have been told that it is likely he will die quietly in his sleep. The ear, nose, throat specialist told us that the only solution is a tracheotomy. However, he warned us that because of Franky's sinus problems, the only feasible way for him to have a trach would be to institutionalize him. That is not even a possibility for us.

My experience with the medical profession has been mixed. We have lived in three different parts of the country since Franky was born; so we have had various experiences with doctors and nurses. There are some very compassionate doctors and those who are hard and almost cruel. Many are indifferent. I guess they don't know how to react to a child who is not "normal." Franky goes to a large clinic with several pediatricians. Because he is on Medicaid our options are limited. We ended up seeing a physician's assistant, Ms. Jeanne Russell. At first I was hesitant, but after four years we feel very comfortable with her. She is very knowledgeable and doesn't hesitate to ask the pediatrician's advice. However, we have found that if she doesn't know, the doctors don't know either. I mention this because, children with special needs sometime require more time and attention than a busy pediatrician can or is willing to give. With Ms. Russell and other physician's assistants I have dealt with, I always feel like they have more time to spend with me. Ms. Russell is always willing to listen to my opinions and questions. I don't feel like a bystander.

We have lost and gained many friends over the years. The friends we have are those who are there for us. No, they don't always have the time or the ability to help with Franky's special needs. Sometimes they are nervous around him and don't know the right thing to say at the right time; but they give us a shoulder to cry on, pray for us and help with our other two children. They don't say, "I know what you are going through," because they don't know. Our lasting friends are there for us when we need them.

A pediatrician recently offered to help us place Franky in an institution. I know that some people have no choice, and I cannot judge those who have had to make that difficult decision. But as long as I am able to take care of Franky, he will be at home with us.

We love Franky very much. When he was born, I could not imagine living with a helpless child who would remain in diapers. It was a comfort to me that he

wouldn't live long enough for us to face that reality. Today we cannot imagine our lives without him. I know that some day he will be in a better place, where there is no suffering. Until that day, we will enjoy every minute we have with him.

Please feel free to contact Francisco and Connie Vasquez by phone at (903) 758-3189 or by mail at 905 Dudley Street in Longview, TX 75602.

No Small Miracle

By Cindy O'Dell, Parent, Amarillo, Texas

With the hustle and bustle of life, sometimes I forget to take time to be grateful for the seemingly "ordinary" things. My children, Shane and Breezy, have an uncanny knack of jogging me into reality or setting me back on my heels to remember my gratitude for the "ordinary" or little things life offers.

My daughter, Breezy, is hearing, vision and other health impaired. She is an extraordinary child. Doctors predicted that she would not see her first birthday. We celebrated her 10th birthday this summer, and the miracles never cease.

Our home lies in a perfect location to see many of the airplanes and other aircraft approach the Amarillo International and Tradewinds airports (an airport for smaller aircraft) and the Bell Helicopter plant which produces the V-52 Osprey.

One cool, fall evening, Breezy came running and screaming into the house from our garage. Quickly, I ran to see what was wrong. She grabbed my hand and practically dragged me outside.

As we reached the end of the driveway, she began screaming and jumping up and down. The dark of night had provided the perfect backdrop for Breezy to see airplanes flying overhead. Her excitement never wavered as she witnessed three military planes, two private planes, a commercial jet and the V-52 Osprey. As each plane flew within close range over the field behind our home, Breezy began to tremble she was so stimulated by such a rare sight.

These sights are nothing new for the rest of the family. For Breezy, it was one of the most thrilling sights she had ever seen. The sunlight during the day prohibits her

from viewing the clouds in the sky, to say nothing of an airplane. The virtually pitch-black sky coupled with the airplanes' bright lights from the landing gear opened a new window for Breezy's viewing pleasure.

While Breezy was busy basking in the events that most of us consider "ordinary," her brother pulled his car into the driveway. Breezy dashed to the driver's side door and frantically tugged at her brother's arm, practically dragging him to the end of the driveway to share this momentous occasion.

As Shane and I stood watching the night sky as witness to Breezy's new adventure, we wondered just how often we must take "ordinary" things for granted. Her enthusiasm was contagious and once again, my daughter made me put other things aside to take time to be grateful for the little things in life.

With a million things left waiting for me to accomplish, I stopped to say "Thank you, God, for granting such an 'ordinary' miracle."

Dreaming of Another World

By Cathy Allen, Parent, Mesquite, Texas

It's a mother's nature to dream of her children's future. In the beginning the dreams fill us with contentment and hope. And because they make us feel so good, we embrace the dreams in our hearts. Forgetting their fragile nature, we determine that they will be real. As our children grow we must be careful to adapt those dreams to the realities of our children's individual preferences, unique personalities, and circumstances of life.

"Of course! This is obvious!" you may say. In my own experience, however, I have found that getting my heart to accept the realities my mind sets forth is not as easy as it is obvious.

Being a little on the creative, eccentric side, the dreams I have for my children may be a little different in nature than some. I think you'll agree, however, that the dreams that flow from my heart and the dreams that flow from your heart, although different, awake within each of us an equal amount of pleasure.

I want to show my children the simple beauty of nature and of music, the enjoyment of laughter and a warm embrace. Surely these things will enrich their lives whatever vocational path they choose to take. With my boys, I sang to them as babies and now give them musical instruments to explore and enjoy. I take them out on the porch at night, snuggled together in our pajamas and wrapped in blankets, to watch nature's electrical light-show during a thunderstorm. We hike through wooded areas searching for vines to swing on or just the right walking stick.

This is life as I choose to live it expressively, experientially.

My dreams were threatened and their narrowness was challenged with the birth of my daughter Rachel, who is now 4 years old. Hearing impaired, visually impaired, with development delays and other medical conditions, Rachel preferred the safeness of indoors. Her world consisted of sterile, protective environments. Although she was surrounded by and touched with hope, tenderness and intense love, there were also traces of apprehension and grief in every encounter.

I didn't know how to draw her into the life and personality of our family. How could I help her truly experience life when she has minimal vision and hearing?

I watched the vision and hearing teachers attempt to define the world as it is to her. (What does she see, hear, respond to?) I started out hopeful, but ended up discouraged to discover how small her world really was. But one thing I knew. I would have to enter into her world before I could guide her into my own. I swung between optimistic denial and hopeless realism. Neither was a place I could stay for long because each soon evicted me and banished me to the other extreme. As I struggled to find the secret gate that would allow me entrance into her world of deafblindness, gradually I came to a place of optimistic realism.

I understood, at least in part, that her sensory limitations brought her world closer to her. She became intimate with pleasures even more simple than I had attempted to instill in my boys.

Whereas with the boys I lay outside gazing up at the stars dazzling in the clear night, with Rachel I lay on the floor cradling her underneath flashing Christmas lights in a darkened room.

Whereas I had taught the boys many songs and introduced them to music of many styles, with Rachel I found intense delight in the beauty and expressiveness of her tiny hands signing “Twinkle, Twinkle, Little Star.”

Whereas with the boys I encourage their sense of adventure by prodding them to catch a cricket with their bare hands or climb to the top of a mountain to see what’s there, with Rachel I am proud of her courage as she cautiously, but voluntarily, reaches out to touch a bush to discover just what that green thing is. Or when she opens a cabinet door and, after studying the dark recess, reaches into its depth, to determine if anything fills the void.

Recently, Rachel and I sat on a bench swing overlooking a lake as the sun set. Rachel was oblivious to the unique strokes of purple, pink and orange coloring the sky in the distance. For a moment, a twang of grief entered my heart at the thought of the peacefulness she was missing because she could not see the setting sun.

But then, impatient with my distraction, her little hands on either side of my head turned my face toward her own. She drew very near as if to study the distinct design of my features and understand the expression she found there. Then, pointing to a spot on my cheek, she planted a gentle kiss in that very place and did the same on my other cheek. Placing her nose on mine, in a familiar gesture of affection, we rubbed noses as I said out loud, “Nosey, nosey, nosey.” Smiling her bright smile, she clapped her hands and then threw her arms around my neck, squeezing tightly ~ expressing her love and pleasure.

Rachel may never see a magnificent sunset, but she can ‘see’ my face and feel my warm embrace. It is my dream that when she comes to me, she will always find a glimpse of sunshine in my smile and experience the peacefulness of the setting sun in my touch.

Visions of Parenting: More Alike Than Different

By Ron Lucey, TCB Consumer Resources Coordinator

When asked to write about my experiences in being a parent with a vision impairment, I admit to having a real identity crisis. I had never thought of myself as anything but "Dada." My two-year-old daughter, Mary, was the first one to utter

those wonderful syllables, and I was captured forever. William Charles, born in December, will add his own verbal version of my name to his vocabulary later this year. I can hardly wait. I'm holding on to Dada as long as possible. Too soon they will be calling me Dad by way of letting me know they are all grown up.

My experiences as a parent and the experiences of parents without visual limitations are more alike than they are different. My wife, Dixie, and I have all of the challenges other parents have. After Mary was born, Dixie and I chose to reschedule our lives so that our daughter could be at home rather than in full-time day care. Dixie stays at home during the week and works weekends at TSBVI. I work during the week and stay at home weekends. Evenings, Friday outings at Taco Cabana or Chuckie Cheese, and Sunday morning brunch are our favorite regular opportunities to reconnect as a family.

I can certainly attest to the fact that two children are more work than one! Mary was what we call an “easy baby.” She slept through most the night and cried only on occasion. In contrast, William has a much stronger temperament and enjoys loudly expressing his opinions when we would prefer to be sleeping. The dull ache from a lack of uninterrupted sleep was my constant companion for a while. Also, having the support of the other parent while both children are crying and in need of simultaneous diaper change is ideal, but due to our opposite work schedules, this is an often elusive situation for Dixie and me.

One month after William was born, Dixie went out of town on business, leaving me alone for the first time with both children. The previous day, I had irrationally agreed to participate at home in an all-day telephone conference call as part of a work task force. I became a real life “Mr. Mom” from the movie of the same name. All day I had no time to shave or shower, and the flannel shirt I was wearing had served as a burping rag for my son’s frequent bottle feedings. Buckets of dirty diapers, empty baby bottles, toys, and unwashed dishes littered the domestic landscape of our home like a scene from a Civil War battlefield. By midnight, when my wife returned from her trip, I had just finished returning our home to its previous state of order and domestic bliss. Eventually, the job of parenting became a little easier as I readjusted to meet the needs of two children.

During weekends before the birth of William, Mary and I often explored our quiet, shaded Allandale neighborhood with trips to Northwest Park’s playground. We always ended our Saturday mornings at the local bakery for bagels, coffee and

juice. All of these favorite activities were not impacted in the least by the fact that I am visually impaired and don't drive a car. Mary and I just wore out the rubber tires on our infant stroller more quickly than other families.

On occasional weekdays, Dixie has out-of-town business travel for a second part-time job. When this occurs, I muster my final reserves of patience to deal with public transportation. The use of taxicab vouchers allows me to take my daughter to her doctor's appointments and to her Mimi's house for occasional childcare. Mary is simply growing up with the notion that Mama drives the family car and I pay money to people who drive taxis. In her children's book she loves to point to the picture of a yellow taxi and say "Dada."

During reading time in our home, we all share in the bonding experience of a well-worn children's book. I have been fortunate that my daughter's favorite books are the "Spot" series by Eric Hill. The Spot books are rich with manipulative flaps that hide all of Spot's animal friends. The jumbo bold print is easy for me to read without a low vision device. I occasionally must use my hand-held magnifier to read the smaller print in other books. At first, this behavior confused my daughter, but she has come to accept it as part of the reading routine.

Throughout my day I use adaptive skills for parenting without consciously thinking about them. I can recall giving my son a bottle at 3:00 a.m. in near total darkness and placing my fingers along his chin and jaw line for proper bottle placement. When traveling on foot with my daughter through busy intersections, we wait through one cycle of traffic lights and cross safely with the next parallel traffic surge. When writing a check at the grocery store, I may fill out most of it beforehand with a CCTV and fill in the check amount with a low vision aid at the checkout counter. However, these minor adaptations do not change the fundamental essence of parenting.

Inevitably a person will question how a blind or visually impaired person can safely parent two young children. The safety and care of my children are always in the forefront of my mind. Although Dixie might be tempted to testify that I have compensated for my vision impairment with being overly safety conscious and attentive to minor details, I think my basic personality may be the stronger force behind my carefulness. We have what every parent should have, smoke detectors, fire extinguishers, first aid kits, and child safety devices. Reasonable housekeeping

practices and always being aware of my children's environment and what they are doing, keeps me reassured that they are safe.

At the end of a long day filled with work and family activities, parenting my two young children may not be any different than parenting for any other dad. I accept that other parents who are blind may use different adaptive skills. However, I believe that any person who is confident in their independent living skills and emotionally prepared for parenting can be successful at this most challenging and rewarding full-time job.

My Favorite Relative

By Patricia Mejia, Sister, Kingsville, Texas

My favorite relative is Riqui Mejia; he is blind. There are so many things I like about my brother. Here are mostly all the things that make my brother my favorite relative.

My brother is tall and five years old. He weighs about 28 or 29 pounds. Don't you think that he's a little too skinny for a five-year-old? His eyes are dark blue and light blue. He has black hair and big feet.

When he's around other people, like my friends and cousins, he likes to act silly and be cute. I like to play outside with my brother in my spare time. We play ring around the roses and swing on the swings.

His favorite thing to do is jump on top of the sofa. When he starts to cry, we have to turn on the blender.

He also likes to walk around a lot. If I go outside, he has to go outside. When we are outside cooking in the backyard, I play basketball. Riqui loves to play with round balls. So I pick him up, sit him on my shoulders, tell him to throw, and he throws the ball. He misses, but we keep on trying until he makes it.

Riqui is cozy as a bear and sweet as honey. When you're in a bad mood, he helps you to be happy again by being silly. These are all the reasons why I choose Riqui Mejia as my favorite relative.

Interesting Websites - Check Them Out

WELCOME TO HOTBRAILLE.COM! -

[HTTP://WWW.HOTBRAILLE.COM/PUBLIC/WELCOME.HTM](http://www.hotbraille.com/public/welcome.htm)

HotBraille is the first and only web-based Braille transcribing service. Now you can send FREE BRAILLE in the mail in 19 different languages to anywhere in the world, all from the comfort of your web browser! Once you sign-up you may access other e-services as well. HotBraille's Member Directory is a place where you can meet and interact with other Members who share your interest in Braille and the blindness field. HotBraille is committed to growing its services and resources aimed at making the Internet a better and more valuable network for blind and sighted users alike. Read more about HotBraille in their Frequently Asked Questions section.

HANDS - [HTTP://MAELSTROM.STJOHNS.EDU/ARCHIVES/HANDS.HTML](http://maelstrom.stjohns.edu/archives/hands.html)

In the words of HANDS's founder, Chris Peterson, "HANDS is a support list primarily aimed at blind high school and college students. Pretty much anything goes as long as members feel the need to discuss it. We don't encourage political announcements or commercials, but if they happen they happen. The main thrust of the list is to let blind students exchange techniques for dealing with student life and to allow them to vent their frustrations, but we've been known to discuss a good movie or book from time to time, too."

A Different Way of Working with Early Language

By Dr. Wendy Drezek, Infant Teacher, San Antonio, Texas

Children normally learn language through their interactions with people and things in the world. They learn the give and take of communication. They learn that language gets them what they want. They learn what words mean by watching what is happening while adults talk. They get feedback from others through their facial expression, posture and proximity, as these make communication more or less effective. All this learning depends on vision.

When vision is poor, children get less information about the world. They get less feedback about the effect of their communication on others. They may be more passive and interact less with people and things on their own. Children with poor vision are less aware of distant objects, and request and refer to them less often. Adults try to help by doing more for the children so the children have less need to initiate communication. Meaning is less clear when the 80-90% of information that is visual is absent or unclear. So, children with visual impairment frequently have weak language.

ASSESSMENT

In traditional ways of assessing early language, children are asked questions or required to identify objects or pictures. They don't have opportunities to generate their own responses. Their responses are prestructured by adults. These approaches may assess a child's ability to imitate responses or follow directions, but they don't access what the child can initiate to change the environment.

On the other hand, totally unstructured collections of language have a different limitation. For example, you can keep a running log of the child's utterances, and analyze it only for length, syntax and meaning. If you don't consider the appropriateness of the language to the situation, however, the child's ability may be overrated. Children with visual impairment frequently use long correct sentences without appropriate content. Repeated questions and echoed speech are examples of correct structure with inappropriate content. The problem of prestructuring can again occur if adults cue all the language.

Traditional assessment can be supplemented to address the children's ability to use their language systems without adult structure. To assess a child's ability to create language in a situation, a language log using specific guidelines is necessary. The observer and child must have shared the activity, for example frosting a cupcake, so the observer knows what the content should be. In this situation, two kinds of assessment are useful. First, the observer can booby trap some aspects of the activity so the child has to generate new language to get what is desired. (The observer might provide a frosting can which is sealed so the child has to request help to get to the frosting.) Then, after the activity, the observer and child talk about it, with the observer using "Tell me about the cupcake" as the only cue to assess what information the child can produce.

IMPROVING LANGUAGE

The problems with improving language are similar to those of assessment. Much of standard language programming relies on prestructured responses answering questions, labeling, imitating, pointing to selected pictures or symbols, or highly cued responses. While these can be useful parts of a program, the goal of any language program has to be a child who can initiate and create communication without adult structure.

The first step in any language program is to make sure there are things the child wants, so communication has a purpose. For many children, such desires are evident. For some children, wants may need to be fostered through appealing activities or especially interesting objects. Doing less for a child, and “not understanding” what the child wants unless the child communicates, encourage more requesting. To build meaning, children will need systematic exploration and activity which pairs language with hands on experience of the available world. Signs, pictures and objects can be invested with meaning by being paired repeatedly with action and many sensory experiences.

Natural consequences are used at the earliest stage of language acquisition to get more output and more specific language. A child can choose between a snack or a favorite toy or nothing. Gradually the child will learn to choose the symbol or use the word or sign for the desired end. Using “ba” which is used for ball, to try to get a cookie, results in a physical therapy activity on the ball. “Kuh” gets the cookie.

Booby-trapping, or building in problems that require language to solve them, is one way to encourage the child to produce language without cues. Responding to a repeated question by ignoring it, or to an echoed statement by responding to its meaning rather than its intention, are natural consequences which make that kind of communication less rewarding. If Bob, who wants a cookie, says, “What do you want Bob?” to get the cookie, and no one gives him a cookie since the question is addressed to himself, he will learn eventually that an echoed question is not a request. If the adult thinks, “I know he wants the cookie.” and gives it to him, Bob is learning that an echoed question is an appropriate request. In general, any adult interpretation of inappropriate statements as appropriate will weaken the child’s language.

It will strengthen language independence more to ask, “What do you want?” at free play, so the child has to use the internal system to form a response; than to play

20 Questions and give multiple choices. At the very early stages of language, however, choices are essential, and even inappropriate responses may need to be encouraged. For some children, consistent responses will need to be identified, developed and refined.

The language logs can also be analyzed for kinds of language use, weakness in the appropriateness of the language, and to assess the depth and overall strength of the child's language. Specific patterns can then be identified and addressed. For instance, if Suzy calls a broom a "sweep-it-up" and a watering can a "pour-it-out," it is clear that she has trouble relating the function of an object to its label. This can then be addressed in activities in which functions and labels are stressed.

CONCLUSION

Traditional language assessment and programming may produce an inflated evaluation of the child's ability to use language independently. It may be useful to include measures and activities to assess and encourage spontaneous appropriate language.

Editor's note: If you have questions, or would like more in-depth information about this unique approach to language development, Wendy can be reached by phone at (210) 493-0939 or e-mail at StanwenDre@aol.com.

What a Concept!

By Jim Durkel, CCC-SPL/A and Statewide Staff Development Coordinator
(with help from Kate Moss, Stacy Shafer and Debra Sewell)
Texas School for the Blind and Visually Impaired Outreach

Communication has three parts. The most noticeable part is the "form." Form is how the communication happens. It is the behavior used to communicate. Speech is one communication form. Sign language is another. Crying, using objects, using pictures, even falling asleep - all of these are behaviors we do, forms we use, to communicate.

"Use" is another part of communication. What is the purpose? Is it to share information, direct another's attention, request something, ask or answer a question? All of these are reasons why we communicate.

The third part of communication is called “content.” Content is the part of communication that deals with meaning. It is noon. I am hungry. I walk up to you, look at you and say, “Lunch?” My voice rises at the end of the word, and I raise my eyebrows when I say it. Those are the ways I communicate, my forms (we usually use several at once). I am using these forms to ask you if you want to have lunch with me. That is why I say that word to you in that way. It is the reason I am doing this. But what does “lunch” mean? What is the content? Am I asking if you want to go eat and drink somewhere for 2 hours, or am I asking you if you want to go to McDonald’s and be finished in 30 minutes? Am I asking you to cook this noon meal for me as you have for the last 20 years, or am I offering to cook it for you? You and I probably have a shared idea of what “lunch” in this context means. We understand that other people may or may not use it as we do. The shared idea is the “content” part of communication.

This content develops as a result of several things. First, you and I have decided what the word means to each of us. This was not taught to us. We “figured out” the meaning. We heard it used at the same time everyday. We did something the same way as we heard it (or very shortly after we heard it). More than likely, there were actions, smells, tastes, sights, sounds, objects and maybe other people involved in what we did when we heard the word.

We developed our own meaning or concept for “lunch” based on our personal experiences. Even if we did not hear the word “lunch” used, we still developed an understanding of what happens at a noon meal. We discovered how it was the same as other meals (we sat at a table, we ate food) and how it was different. (We did not eat cereal like at the morning meal, and we usually did not eat as much as at the evening meal.) We developed a concept of lunch.

Once we had the concept, we paid attention to the form (“lunch”). We heard the word “lunch” every time we had our noon meal. Next, we figured out if that form referred to the same concept for all people. Some folks eat “dinner” at noon! Last, we figured out how to use that form in certain ways to get people to fix us lunch or eat lunch with us.

Children with visual impairments, including deafblindness and children with multiple impairments, have difficulty developing concepts. They have difficulty understanding how the world works, how parts of the world relate to other parts,

how these parts are the same and how they are different. What makes the communication of children with a loss of vision really different from the communication of other children, is that many of these children often use communication forms without having the content or meaning or concept firmly in mind. Often, children with a vision loss are good at hearing, remembering, and using words without having a real “gut” sense of what they are saying. I do the same thing whenever I try to talk about football. I know the talk, but I can’t walk the walk. I know labels (“tight end,” “Hail Mary Pass”), but I did not have the experience of playing football. I do not really have concepts for these words.

Many people think of concepts as things like “right,” “left,” “top,” and “bottom.” These are a particular type of concept having to do with positions in space. But “tree” is a concept, as is “dog,” “house,” “push,” and “work.” There is the concept of “book” and of “reading.” Concepts can also be about events, such as “going shopping” or “visiting Grandma.” The story of “Snow White” is a concept. And so on. All the words we know, all the language we speak and read, have underlying concepts. Some concepts are expressed in one word, like “lunch.” Other concepts are expressed only by using several words in a specific way, “After I run some errands, I will eat lunch.”

Impaired concept development will impact learning later in life. For example, most teaching after second grade is not “hands on.” Students are expected to read about and/or listen to the teacher talk about something. For students who have good experience-based concepts, this kind of learning is OK. So what if you have never been in an igloo. You understand houses, and you understand how various kinds of houses are different and how they are the same. You understand that not everyone lives in Central Texas, where ice outside is a rare thing. You understand ice and how it can look like a brick. You can read about an igloo and relate what you read to what you know. If those basic concepts are shaky, your understanding of what you read will be shaky too. Even if you can say all the words, read all the print, or read all the braille.

When I say concepts, many people think, “label.” They think we should always be talking to children with visual impairments. They think the underlying problem is that children “just need the words.” But this is not really true. Concept development is delayed because vision is what drives the typically developing infant to move and interact with objects. When vision is impaired, often this drive is also impaired. Babies with visual impairments do not handle objects in the same

way that babies with no vision loss do. They do not explore the environment the same way. They also do not see the actions of others well or at all. They cannot rely on vision to give them information to the same extent that babies with no visual impairment can. Vision also allows one to see how one piece of the world relates to several other pieces of the world. Children with visual impairments have to view their world piece by piece; then put it all together into the big picture. Children with no visual impairment can see the big picture first; then look at the pieces; then go back to the big picture. For example, a child with no vision loss will see that I am holding a rattle. She will look at the rattle and at me, and she gets the picture that the rattle is “attached” to me. A child with a visual impairment will hear the rattle, maybe see it, but may not understand that the rattle is “attached” to me. For that child, objects appear to float in space, unless we help her get the big picture. All of these things happen during an early time of learning called the sensorimotor period.

The sensorimotor period was named by Jean Piaget, a French psychologist. He studied how children developed concepts and made sense out of the world. He believed that children “constructed” these concepts through active exploration and interaction with the environment. Most of this exploration and interaction took place during play. Piaget said that the sensorimotor period in most children lasted from birth to the age of 2 years. During this time, children learn about their bodies, their own actions and the actions of others. Children also learn about the properties of objects and how objects are used. Children begin this learning by accident, then through their own deliberate movement, then by watching others. This is a time of developing concepts about how the world works through the use of sensory and motor (sensorimotor) skills.

Jan van Dijk, a Dutch psychologist who works with children with deafblindness, says that all we know can be traced back to our actions. He gives the example of asking us to define a castle. We say, “It is where the queen lives.” He responds, “Yes, tell me more.” We say, “It has towers and big gates.” If he keeps asking questions, eventually we say it is where people eat and sleep and play. And, that eating, sleeping, and playing means using certain objects in certain ways. We have used these objects and performed these actions. These are concepts that we usually develop during the sensorimotor period.

Our experiences can give us concepts that are very unique to us. You probably heard the story of the woman who called her mother to ask about how to make a

roast. Mother told her to get the roast, cut off the end, rub it with oil and pepper, put it in a pan, and bake it in the oven for a period of time. The roast was great, and later Daughter asked Mother why she had to cut off the end of the roast. Mother said she did not know but that was how her mother did it. When they asked Grandmother why they had to cut off the end of the roast, Grandmother said she did that because otherwise a roast would not fit into her pan.

We all have our unique ideas about the world around us. If you use chairs as something to hold on to and push around the room to help you walk, your concept of “chairness” may be different than mine. (I think they are to put my legs on when I sit on the table.) Children with visual impairments are not incapable of learning the concept of “tree.” But their concept may be very different than mine because we rely upon different senses and have different experiences of “treeness.” A 2-year-old with a visual impairment may know all about rustling leaves, a piece of treeness I did not learn until much later in life!

Kurt Fisher, an American psychologist, says that we put together basic concepts into bigger and bigger “chunks.” For example, we learn about how one object can be stood up on top of one another. Another time, we learn that if we push a ball, it will roll. Another time, we learn that a rolling ball can knock over things. We put all these things together when we set bowling pins upright on the floor and aim a bowling ball at them in order to knock them down. Sensorimotor concepts that we can use as adults!

Some people call these bigger chunks of basic concepts, “scripts.” A script usually involves a series of actions. We have a script for going to the grocery store. We get our cart, walk up and down the aisles, put food in the cart, and then pay for that food. Some of us may have parts in our scripts where we eat the free samples, some of us don’t! We learn how a script for buying food at a Walmart superstore is different from buying food at a convenience store.

We also develop more abstract and more complex concepts, as we grow older. We learn about the physical world in science classes. We start by dividing the world into things that move and eat and things that don’t. We don’t stop categorizing until well after we are discussing bacteria and plankton and chemical compounds. We learn about our own bodies and our lives; then learn about our friends’ lives; and then we are discussing Arab-Jewish relations in Israel. We learn about in and out and on and off; and then we are booting up computers, putting in

our floppies and typing away. But all these concepts start with what we learn in the sensorimotor period. They start with our own experiences, not what we have been told about another person's experiences.

How do we help a child with visual impairments develop a solid base of concept development? The key is not to so much tell the child about the world around them, as it is to provide the child with experiences that allow them create these concepts for themselves. For example, telling a child who has no vision about you washing dishes is not as good as having the child right there with you. She needs to learn about dish washing as she feels the suds, experiences the dirty dish going into the water, notices the difference between the wash water and the rinse water, and touches the dishes in the dish rack. You can use words to describe what the child is experiencing, but don't use words without the experience.

Another way to help the child develop these concepts is to give them opportunities for exploration and play. The OT, PT, Orientation and Mobility Specialist, and Teacher for Students with Visual Impairments all need to work with families to help children develop motor skills they can use to explore the world. Sometimes this means that children need "help" to move independently. Sometimes it means that children need toys that sound interesting to encourage exploration or toys that feel interesting, or toys that we know the child can see and will enjoy examining.

A child with visual impairments needs to have routines in order to learn how pieces of the world are connected. We need to provide an environment that is predictable. How is eating different than bathing? Each happens in a predictable place, with distinct objects and actions, and at certain times during the day.

A predictable environment is also one where I can find things easily. During the first part of the sensorimotor period, children without a vision loss "forget" about things they can't see. Gradually the child learns that objects do continue to exist, even when they are out of sight. This is a harder concept for children with visual impairments to learn. Anything these children can't touch or hear is gone. We can help these children learn about the permanence of objects by creating a situation where objects are easy to find and where objects don't get lost quite so easily. We can do this by attaching toys to a frame with string or by putting the baby in a play pen with her toys velcroed to the same place on the floor or to the slats every time. We can make sure a toddler's toys are always in the same place, and that the toddler

has lots of landmarks to use to find those toys. We can look for toys that make sounds, so the child can hear them even if he can't see or touch them. (We need to remember that reaching to a sound happens later in the infant's life than reaching for an object he can see.)

Children need toys that help them make comparisons. If we give a child blocks to play with, we should give her all types of blocks. She needs LEGOs and wooden blocks and big blocks and small blocks; so that she can compare and discover for herself what makes a block a block. Some important comparisons are materials (wooden spoons vs. metal spoons), size (big spoons vs. small spoons), shape (a plain spoon vs. a spoon with Bugs Bunny for the handle), number (one spoon vs. many spoons) or the objects themselves (spoons vs. forks).

Toys and objects should respond to the child's actions. The child needs to have things that she can squeeze, rattle, open, close, stack, turn, pull apart, and put together. The child also needs things that get warm when she holds them, things that move when she pushes, and things that make sounds when she blows through them.

Provide the child with real, every day objects. Pots and pans, cups, plates, forks, blankets, brooms, TV remotes, toilet paper, towels, and sponges.

We need to provide experiences. We need to take the child with us to the store, post office, and dry cleaners. We need to explore parks and malls. We need to have the child with us while we wash dishes, make beds, prepare meals, put gas in the car, shine shoes, fold clothes, and plant flowers.

Hooking new learning on to old concepts is one way to help the child learn more about her world in a meaningful way. It allows the child to try new things and change her ideas about the things she already knows. New things should not be totally new. We need to introduce new things to our children in a way that does not scare them. Some part of the new thing should be familiar to the child. If we are introducing a new object, is there some way the new object is like something the child already enjoys? Is it the same size, the same color, the same shape? Can the child try familiar actions such as banging or opening or rolling on the new object? Does the new object make the same noise a familiar object makes?

Children need lots of time to try something over and over in order to make sense of it. Let your child play. Let your child direct the play. You can join in and play with your child, but do what she is doing before you try to show the child something new. Let the child know that she can have interests of her own, and then that you can show her new ways of doing things.

Concept learning and teaching should be fun for both adult and child. It is exciting to see children discover the world. It is thrilling to see children having new ideas. It is a joy to be part of that discovery and learning.

Second Language Acquisition and Children with Visual and Hearing Impairments

By Maria L. Muñoz, M.A., CCC-SLP

FIRST LANGUAGE ACQUISITION

Babies are born with the ability to distinguish speech from other sounds they hear, even though they do not understand what it means. By the time children reach school age, they are speaking in complex sentences, having conversations, and understanding most of what they hear. How does the development of language occur?

Children's brains are designed to help them learn language. From the time they are born, their brains register and process the sounds they hear. As a child's brain, thinking skills, and motor systems develop, so does his/her understanding and use of language to communicate. Underlying language development is the ability to think about the world, and explore it with vision, hearing, smell, touch, etc. As a child begins to make sense of the world through exploration, language is attached to those experiences. Language develops gradually, from single words at about twelve months to complex sentences at five years, and from simple concepts (juice, shoes) to those that are more abstract (frustrated, addition). School-age children continue to learn and use increasingly complex and abstract language.

Because early language develops through sensory exploration and understanding of the world, language development for a child with a visual impairment or deafblindness will be effected by the nature and severity of the sensory

impairments, and by other factors such as motor and cognitive skills. Some children with mild to moderate vision and hearing losses can be taught to compensate for limited visual and auditory information. They do this by using their other senses, thinking skills, and hands-on experiences to learn the meanings associated with words and sentences.

SECOND LANGUAGE ACQUISITION

The development of a second language can occur in different ways. For example, a child may be exposed, from birth, to two languages at the same time; or a high school student might take a foreign language elective. I want to talk specifically about children who learn a language other than English at home, then begin to learn English when they enter school. Depending on the parents' requests and services offered by the local district, these children may be placed in an English speaking classroom, an English as a Second Language (ESL) classroom, or a Bilingual Education classroom. It is important to note that a child's classroom placement will have an impact on the development of both first and second languages. Bilingual education classes foster development of skills in English and the child's first language. ESL classes only support skill development in English, a strategy that may be associated with slower acquisition of abstract language.

In general, these children enter school with proficiency in their native languages, which they then use as natural foundations for learning English. The process of acquiring English is gradual and follows a pattern of development similar to first language acquisition. For example, simple sentences are produced before complex ones. Children make errors in English that reflect the linguistic rules of their first language. For example, a Spanish speaking child may say, "I want the ball green," because in Spanish speech, adjectives are spoken after nouns. Conversational skills are acquired (in about 2 years) before the abstract language required in a classroom is fully developed (in 5 to 7 years). These children still learn language best through exposure and experiences.

Second language acquisition, however, often occurs during classroom activities where specific, targeted English skills are being taught, rather than through the hands-on experiences typical of first language acquisition. Children are challenged to learn English quickly, while keeping up with the new concepts introduced in their classes every day. They have little time to learn basic English before it must be understood and used in highly abstract and decontextualized academic activities.

VISUAL AND AUDITORY IMPAIRMENT AND SECOND LANGUAGE ACQUISITION

Generally, it has been assumed that if a child's first language develops normally, the second language will also develop normally. Why might this assumption NOT be true for children with visual impairments or deafblindness?

Many professionals, including myself, have observed that verbal children with visual impairments or deafblindness sometimes have great difficulty acquiring a second language. They also may have difficulty transitioning from bilingual education to English-only instruction. I think the differences between learning a first and second language come from the ways those two languages are acquired. As with all children, verbal children with visual impairments or deafblindness also learn their first language gradually, over many years. While the information they are getting from the environment is reduced, within the context of multiple, highly meaningful, multisensory experiences, other senses are used to support and compensate for limited visual and auditory information. A foundation of relatively normal language is built, upon which is added the complex language required in school.

Second language instruction in a classroom is by nature primarily visual and auditory. One language is used to teach another language, either through use of the first language or by simplified explanations of concepts in the second language. Because children are expected to use and understand abstract academic concepts in English almost immediately, they often don't have time to develop complex language gradually. Children with visual impairments or deafblindness have difficulty compensating for the limited or distorted information received through their visual and auditory systems. They often cannot use touch, smell, taste, or movement to learn abstract concepts that are taught visually and auditorially. Therefore they must rely upon prior knowledge to understand what they are hearing and seeing. They can quickly and easily miss or misunderstand the concepts being taught.

Here is an example of how a student with deafblindness might have difficulty with second language acquisition. Juan, a Spanish-speaking student with a visual and auditory impairment, is in a class that's beginning a study of oceans. The teacher shows a slide of the beach. (Juan sees a light and dark blur, but doesn't recognize the picture.) The teacher says, "We are going to study oceans." (Juan

hears “oin.” Due to his hearing loss, he can’t hear /s/ or /sh/. He’s not sure what an “oin” is, and can’t see the slide well enough to figure it out.) Next, the teacher shows a slide of a fish and says, “We are going to study saltwater fish.” (Juan doesn’t know what a “altwatei” is and, again, can’t see the picture. With his limited English proficiency and hearing impairment, he doesn’t realize that two different words were spoken.) The teacher then asks the class to write a short paragraph about oceans. (Juan looks around and sees the other children writing, but is confused and does not understand the topic.)

In this example, Juan isn’t learning the English vocabulary because he cannot hear it clearly. He’s unable to fill in the auditory gaps with pictures because he cannot see them. Reduced auditory and visual input prevents Juan from recognizing the topic, and he doesn’t realize that the class is discussing familiar things; “mar” (sea) and “pez” (fish). Language learned in this context is very different from learning about oceans by going to the beach, playing in the sand and waves, smelling the salt air, and feeling fish brush against a leg. Juan’s ability to learn English is limited by the highly visual and auditory demands that are emphasized in his classroom setting.

A FEW SUGGESTIONS FOR ENCOURAGING SECOND LANGUAGE LEARNING

1. Consistently implement modifications and devices used to improve hearing and vision, such as hearing aids and glasses.
2. Whenever possible, teach children through hands-on, multisensory activities that will help them learn experientially as well as linguistically.
3. Use a child’s native language to support understanding of the second language.
4. Help children understand the relationships between new concepts that are being taught and their familiar experiences.
5. Children may require specific training in their second language, to discriminate between speech sounds and to identify word boundaries. These are critical skills for the development of reading and writing.
6. Periodically check a child’s notes and ask questions to verify concept comprehension, making sure that visual and auditory information is interpreted accurately.

RESOURCES:

Guinan, H. (1997). ESL for students with visual impairments. *Journal of Visual Impairment and Blindness*, 91(6), 555-563.

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Checking Hearing Aids

By Gigi Newton, Teacher Trainer, TSBVI Texas Deafblind Outreach

As I travel around the state, visiting children with deafblindness in their homes and classrooms, I always check the child's hearing aids. Since these children need to make use of all of the sensory information available to them, having hearing aids that fit and work properly is very important. Unfortunately, many times I have found hearing aids that weren't working properly. In one instance I checked the hearing aids on a child when I arrived at a school mid-day. I discovered that for two hours he had been listening to a "hiss" because the aids were set on "T" for use with a telephone. His hearing aids had effectively blocked any possibility of him hearing any sound other than that hiss. The reason this had happened was because the teacher and the paraprofessional did not know how to check the hearing aid. This should not ever happen for any child with a hearing impairment, but especially not for a child with deafblindness!

The classroom that has a child with a hearing impairment should have a hearing aid stethoscope and battery tester to check the hearing aid every day. Classrooms should also have a supply of extra batteries. In addition, IEP modifications and strategies should include the assignment of a staff person who will be responsible for checking the hearing aid on a daily basis. Regional Day School Programs for the Deaf (RDSPD) staff can demonstrate how to check hearing aids.

A videotape, *Hearing Aid Management Skills for Families of Young Children Who Are Deaf or Hard of Hearing* (Item #206), that can help is available through Hope, Inc. for \$42.00. Parent advisors are shown explaining and demonstrating basic concepts and skills related to the management of the child's hearing aids such as understanding the anatomy of the ear, hearing tests, the audiogram, identifying parts and function of the hearing aid, putting the aids on the child, giving the hearing aid a daily listening check, establishing full-time hearing aid use, and troubleshooting for the source of feedback. Additionally, the INSITE curriculum, Volume I (pages 300-397) also addresses hearing aid management. It includes the same topics as the tape in print format. The two-volume set is available from Hope, Inc. for \$115.00. Order the video or reading information from:

HOPE
1856 North 1200 East
North Logan, UT 84341
Tele/fax: (435) 752-9533
Web site: <www.hopepubl.com>
E-mail: hope@hopepubl.com

You can also purchase a Hearing Aid Care Kit from HARC Mercantile, Ltd. for \$33.50. This particular kit includes: a dehumidifier and storage case, stethoscope, forced air blower to keep earmolds dry, a mini-brush for cleaning the outside of the hearing aid, a wax remover tool, and a battery tester and holder. Similar kits may be available from other sources; check with your local audiologist or hearing aid distributor. Their contact information is:

HARC Mercantile, Ltd.
P.O. Box 3055,
Kalamazoo, MI 49003-3055
Phone/Voice/TTY:(800) 445-9968;
Fax:(800) 413-5248
Website: www.harcmercantile.com

STEP ONE: EXAMINE THE AID FOR DAMAGE

Hearing aids take a beating, especially from children. Make sure the case is not cracked or broken, that there is no visible sign that the aid has recently visited the toilet, or that the earmold is not plugged with earwax. If you notice major

problems, make sure that the parents know about it right away. Classroom staff can sometimes handle problems, such as wax in the earmold. Other times the aid will need to be returned to the dealer. Sometimes a good audiologist, speech pathologist, or teacher of the deaf and hearing impaired can address the problem, especially if it is just a broken cord or moisture in the aid or earmold. Staff members should be clear about who can address which types of problems and be instructed on regular maintenance.

STEP TWO: CHECK THE BATTERY

Battery testers can be purchased from any number of variety or hardware stores such as Walmart, Home Depot, or Radio Shack. Some will check any size or type of battery, and some are designed to check only the small, flat type of battery used in hearing aids and watches. They are fairly inexpensive; one that will do the job of checking a hearing aid battery can be found for as little as \$7- \$10.00. Different hearing aids use different size batteries, so it is important to make sure the tester is set to the correct setting for the size of battery your child's hearing aid uses. The size of the battery is written on the battery. Generally all you need to do is touch the + (positive) end of the battery to the + (positive) wire or point on the tester and then touch the - (negative) end of the battery to the - (negative) wire or point of the tester. An indicator of some type will register whether the battery is "good" or needs replacing. Batteries should be checked every day, even if you put a new battery in just the day before.

STEP THREE: USE A STETHOSCOPE TO LISTENING TO THE HEARING AIDS

Once you have examined the aid and checked the battery, you need to listen to sound quality of the hearing aid. It is not enough to hear a whistle (feedback) from the hearing aid and assume it is working correctly. You need to listen using a device called a hearing aid stethoscope. A hearing aid stethoscope looks similar to a doctor's stethoscope except that it has a coupler that fits onto the earmold. When the hearing aid is turned on, you can listen to the sound quality.

It is a good idea to listen to the hearing aid every day to detect sound problems that can occur as a result of a short in a cord, moisture or dirt in the aid, or other problems that impact the aid. You can also detect sounds that would indicate that the hearing aid is set on the telephone setting. HARC Mercantile also sells an inexpensive stethoscope individually for testing hearing aids. The part number is HAC-3000A. The price is \$16.00 plus \$5.00 shipping.

Be sure the aid is set on “M” for microphone, that the volume is at the lowest setting, and that the aid is turned on. Slowly adjust the volume. Listen to the environmental sounds; then listen to your own voice. Say the vowel sounds such as ah, ee, oo, i and also consonant sounds such as b, t, s, sh. The sounds should be clear. This is a nice place to start teaching the child to check his own hearing aid. You can have him vocalize for you, while you listen; then you can vocalize for him after the aid goes in his ear and have him listen. This is also a nice turn-taking activity and a way to work on vocalizing.

STEP FOUR: CHECK FOR FEEDBACK

Place the earmold in the child’s ear after the aid is set on the volume recommended by the audiologist. The earmold should fit securely in his ear and should not whistle (this is feedback). If you do hear feedback, remove the aid and cover the opening of the of the canal in the earmold with your thumb. Turn up the volume. Do you hear feedback? If you do there is a problem with the aid itself. If not, you know the problem is the earmold is no longer fitting the child. New earmolds need to be made frequently (every 4-6 months) for a young child who is growing rapidly.

CONCLUSION

Just like glasses, hearing aids will not help a child if they are not worn. They also will not help him if they are not working properly. No child should ever have to suffer an additional hearing impairment because the professionals are not making sure the hearing aids are turned on, set properly, and working. If you are not sure how to check your child’s (or student’s) hearing aid, contact a teacher of the deaf or hearing impaired or the hearing aid dealer or audiologist who prescribed the aid. You wouldn’t let a child use a wheelchair that was broken. Why should you let him use a hearing aid that wasn’t working?

Making It! Successful Transition Competencies for Youth with Visual Disabilities

By Dr. Karen Wolffe, Career Counseling & Consultation
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This article is based on a presentation given at the 1999 Texas AER conference. The presentation focused on the essential elements of successful programming for preparing children and youth with visual disabilities for life and adult responsibilities. There are numerous skills that all young people must master, in

order to leave school prepared to contribute to their communities and participate fully in life activities. A youngster with a visual disability who masters the skills outlined here will be ready to meet those demands.

TOP TEN TRANSITION COMPETENCIES

AN UNDERSTANDING OF WORK BASED ON REAL LIFE EXPERIENCES

An understanding of work based on real life experiences begins with chores and expectations for performance at home. By participating in home-based activities (picking up toys, clothes, and materials; washing and drying dishes, setting the table, serving food; taking out the trash; mowing the yard; and so forth), children with visual disabilities learn that they are contributing members of a household. They learn that their families expect them to perform household tasks that benefit the entire family.

Once children are old enough to attend community and school activities, they will benefit from being given responsibilities in those settings. For example, at a church or synagogue function, children can help set up and then put away furniture or materials used in services or activities, hand out printed materials to attendees, or help entertain younger children. Likewise, participation in scouting activities or community group meetings with set responsibilities can help establish the need for individual work that benefits the group. Volunteer experiences with relatives or neighbors and in nearby neighborhood recreation or senior centers can also help children learn the importance of helping others while developing strong work habits and skills.

Following productive efforts without pay at home, school, and in the community, it is important for children with visual disabilities to work for pay. Ideas for paid work experiences that young people can do include entry-level jobs in restaurants, grocery stores, retail establishments, hospitals and nursing homes, recreation centers, lawn maintenance, car detailing, baby-sitting or pet sitting, and so forth.

WELL DEVELOPED SOCIALIZATION SKILLS

Social skills are critical for both life satisfaction and success in the work place. This includes those skills necessary to develop and maintain interpersonal relationships, an understanding of reciprocity, and mastery of effective communication skills, including the nuances of nonverbal communication.

Most children learn socially appropriate behaviors through their observations of those around them: family members, neighbors, classmates, and so forth. This task is more difficult for children with visual disabilities because they either can't see what's happening in the environment or their observations are limited or skewed by their inability to see clearly. This is especially true about nonverbal cues such as winking, nodding, smiling, frowning, shrugging one's shoulders, and the like. Children with severe visual disabilities must be taught these nonverbal skills and positively reinforced to use them.

Caring adults and older children can help in social skill development by giving youngsters without good eyesight verbal feedback about what works and what doesn't work for them in everyday social interactions. They also need to know from those who can see well, what is going on around them ...what their peers are doing when out of their viewing/hearing range, what they are wearing, and with whom they are interacting.

This verbal feedback and information sharing will facilitate the children's understanding about social options available to them. Children must learn that social competence is based on an appreciation of others and that reciprocity (giving and taking from others) is the hallmark of successful social relationships. By expecting children with disabilities to both give and take in social interactions, we set the stage for them to be integrated into the larger community more readily.

WELL DEVELOPED PROBLEM- SOLVING SKILLS

Throughout life, individuals handle problems and problem situations routinely. Successful people learn the coping and strategizing mechanisms categorized as problem solving skills during childhood. The risk for young children with disabilities is that others will do their problem solving for them. These parents, teachers, peers, and people are well intentioned but unaware of the damage they do in the development of this skill area. These folks don't realize how these skills are learned best: by having the opportunity to figure out what to do when confronted with difficult situations or specific problems.

Children with visual disabilities need to learn to identify and analyze problems. Children can identify problems by coming to recognize that when they feel out-of-sorts, angry, frustrated, or confused, they likely are confronted by a problem. The key is to define what it is that is bothersome to them. The next step in problem solving is to analyze the problem by answering the following questions:

- How do I contribute to this problem?
- How do others contribute to this problem?
- How does the environment contribute to this problem?
- What has kept me from resolving this problem to date?

Children who are too young to answer these questions independently may need the caring adults in their lives to help them process this information in a meaningful way. The adults will want to model the process for them of addressing the four areas listed above as an appropriate strategy for analyzing problem situations. Once the problem has been defined, children can be encouraged to consider possible solutions or goals (what it would be like without the problem).

At this juncture, adults and friends can help the person doing the problem solving generate a list of action possibilities things to do to resolve the problem and achieve the solution. All ideas generated by the individual with the problem, and those helping or brainstorming solutions with the person, need to be written down. The person doing the problem solving can then reflect on which solution will work best. It is critical that the problem solver processes his or her choices to determine what to do independently.

Unless the situation is life threatening, children should be allowed to choose a course of action and act upon it. If their plans prove effective and they are making good progress toward resolving a problem, they need to receive positive reinforcement from family, friends, and service providers. If their plans prove ineffective or are never implemented, they need to be confronted (using an empathetic approach) by those who care about them and encouraged to reconsider their plans.

APPLICATION OF SELF-ADVOCACY SKILLS

Self-advocacy involves being able to describe one's disability in functional terms. It also involves being able to discuss any needs for accommodations or modifications in an assertive manner. Throughout their lives, people with disabilities are asked about their differences sometimes in rather rude or inconsiderate ways. Even if other people (prospective employers, teachers, friends, and others) do not ask about their disabilities, they will be curious about how people

with such disabling conditions can work, play, study, and live normal lives. Children who are prepared to handle these inquiries from others and who feel comfortable with the task, are more likely to put others at ease and present themselves well.

As early as appropriate, children need to learn that their vision differs from the vision of other people, but that it doesn't define who they are ---it's just an attribute. They need to respond to questions, but shouldn't feel obligated to provide all the details of their medical histories. A youngster who is unable to see due to Retinoblastoma or Retinopathy of Prematurity (ROP) doesn't need to provide information about the medical condition. He does need to be able to explain his or her functional limitations and may want to add some information about how he or she does things differently. For example, the child might say to a prospective teacher, "I am unable to see to read print, but I love to read and I read both braille and audio books." By focusing on the functional limitation and providing insights into how a specific task is performed, the child helps the teacher understand that the disability is not overwhelming.

APPLICATION OF COMPENSATORY SKILLS

Blind and visually impaired children must learn compensatory skills. These include skills such as reading and writing with braille or with print using optical devices, orientation and mobility skills, technology skills, activities of daily living, career education content, and the like, in order to fully participate in life activities.

Braille and print are the primary mediums for children engaged in literacy activities that involve reading and writing. For children without functional vision or those with severely impaired vision, braille is the medium of choice. In order to be competitive in adult environments, children need to learn to read at speeds commensurate with those of their fully sighted peers. Reading speeds of less than 50 words a minute will inhibit the ability of a person to enter the labor force successfully. Both children with low vision and blind children need to use this benchmark to determine if the medium they are using is appropriate for them to be competitive when they leave school and attempt to secure work.

Likewise, orientation and mobility (O&M) skills are critical to successful inclusion in the larger society. Without the ability to drive to and from work, shopping centers, doctor's offices, and so forth, people with visual disabilities must rely on alternative forms of transportation. Students who learn early in their lives how to get around on foot, by bus, or using other modalities (trains, subways, taxis,

para transit, hired drivers, family, and friends) are more likely to be successful on their own following childhood.

In addition to instruction in alternative literacy media and O&M, students with visual disabilities need instruction in technology skills both generic computer skills and disability-specific skills, including the use of screen enlargement programs, speech and braille output devices, braille embossers, reading machines, talking calculators, electronic notetakers, and so forth.

Finally children must learn to manage their home and personal needs through instruction in activities of daily living. (Career education content competencies are discussed in the following sections.)

KNOWLEDGE OF CAREER OPTIONS AND SOURCES OF INFORMATION

Structured instruction in career education can provide students with essential knowledge of the array of career options available to them. Many youngsters with visual disabilities have difficulty accessing information about the broad range of job choices available to them. This occurs because they cannot casually and serendipitously observe adults performing different jobs.

Compounding this problem is the fact that sighted people who do share information with youngsters about jobs, have a tendency to “filter” information. They share information only about what they think the youngster can do without regard for what the youngster might want to do or be interested in learning more about.

Without good vision it is difficult not only to determine what job choices are available in the community, it is also very difficult to learn about the nuances of jobs: what people wear to work, what kinds of tools they use to perform their jobs, where they work, and how they behave on the job. Sources of general information about jobs and the labor market have traditionally only been available in print. This makes it even harder for young people with significant visual to get this information.

Students need to be taught how to use research techniques that they can apply to this problem: how to use the Internet, how to use recorded materials from the regional libraries for the blind and physically handicapped, and how to perform information interviews. There are a number of materials written in accessible formats that can be introduced to students such as *Career Perspectives* (Attmore, 1990), *Jobs To Be Proud Of* (Kendrick, 1993), and *The Transition Tote* (Wolffe &

Johnson, 1997), that provide good information about job and career research techniques. In addition, resources like *O*Net* and *The Occupational Outlook Handbook* (DOL, 2000), that are available on the Department of Labor website at <www.dol.gov>, are accessible on-line.

An important resource for information is people with visual disabilities who are currently employed in jobs like those in which students are interested. These individuals can be accessed through the American Foundation for the Blind's Careers & Technology Information Bank. You can connect with them either on-line at <www.afb.org>, or via telephone at (800) 232-5463, or by contacting local chapter members of consumer organizations such as the American Council of the Blind or the National Federation of the Blind. By using techniques like informational interviewing and job shadowing, students with visual disabilities can learn firsthand about jobs being performed that they might be interested in pursuing.

AN UNDERSTANDING OF EMPLOYERS' CONCERNS

In addition to knowing about job choices, students need to gain an understanding of employers' concerns with regard to hiring people with visual disabilities. There are four major areas of concern voiced by many employers: safety, access to print, transportation, and the ability of workers with disabilities to meet quality and quantity quotas.

Young people with disabilities need to be prepared to address these concerns. They will need to explain to employers how they have performed previous jobs or work-related tasks safely, using adaptive techniques or modified equipment. They will want to explain how they access and generate printed information and be prepared to demonstrate any assistive technology that they use to do so. They will have to explain to prospective employers how they will get to and from work consistently and on time without driving. And, for employer's concerns to be allayed, they will have to be prepared to demonstrate their ability to perform tasks well and in a timely fashion.

Finally, students need to understand how employers' expectations change over time. That is, they may need to be taught that an employer initially expects to see evidence of good work habits and rudimentary work skills. He or she expects to teach a new hire many of the nuances of the job. New employees are typically oriented to the work site, introduced to their fellow workers and taught how they will be expected to perform their jobs. After the first few months, the employer

expects to see improvement. He or she assumes that a new employee will need less and less help on a daily basis. Employees who have been with a firm for six months to a year are expected to be performing at or near peak performance. Once employees have achieved peak work performance, employers begin to look for a willingness to teach these learned skills to others. They also hope to see a willingness to learn new job tasks and assume greater responsibility, and an interest in career advancement.

MASTERY OF CAREER COUNSELING CONTENT AREAS

An introduction to career counseling content in self-awareness, vocational selection, job seeking, job maintenance, and job search skills can be helpful to a student. It can facilitate a student's understanding of how to make good decisions about employment potential, how to prepare and look for work, and how to maintain a job once secured.

Self-awareness is indicated by a thorough knowledge of values, interests, ability and liabilities, as well as the knowledge of how one appears to others and relates to others. Individuals who are self-aware demonstrate the ability to set goals. This includes daily detail goals, achievement goals, and personality goals; as well as the ability to plan, organize, and discipline themselves in order to achieve their goals.

Vocational selection has to do with knowledge of jobs available in the job seeker's home community that appeal to the job seeker. This selection is based on his or her values, abilities, and interests, as well as those that meet his or her fiscal and personal needs. Student need to have knowledge of how a job seeker's qualifications match a job description and an understanding of how a selected type of work relates to short-term and long-term goals. Finally, the student needs to have the ability to identify places that hire people doing a job like the one he or she has chosen and alternative job choices related to and hopefully leading toward career goals a job seeker has already set.

Job seeking skills are indicated by a job seeker's ability to produce well-written applications, a resume or qualifications brief. He needs to be able to set and keep appointments (includes arranging transportation to the interview); and interview successfully.

Job maintenance skills are indicated by a job seeker's knowledge of how to keep a job, including an understanding of employer and co-worker expectations and how their expectations change over time. Job maintenance skills also include the ability

to discipline oneself and the ability to distinguish between work habits and work skills. The student needs to be able to evaluate personal issues that may result in job maintenance problems. He or she also needs an understanding of job benefits and payroll deductions.

Finally, job search skills are indicated by a job seeker's knowledge of where jobs are advertised and the ability to find job leads or get assistance in finding job leads. He or she should be able to identify appropriate job openings; demonstrate job seeking skills; and to organize job search time. Additionally students need to be able to follow up on job interviews, and keep a record of all job contacts.

AN UNDERSTANDING OF LEVELS OF ABILITY AND IMPACT WITH REGARD TO PLACEMENT

It is important for students to find jobs and solicit only the amount of help truly needed by external sources. In order to do this, students and their teachers must understand that a person's level of ability drives the amount of assistance that will be required from others in a job search. The three levels of intervention: informational, instructional, and advocacy.

Informational people are good readers and observers. They can be given involved verbal directions and be expected to follow through. These individuals cope fairly well with the traditional content approach to teaching. A teacher can lecture or lead discussions in topical areas and informational students can apply what they have heard and seen. These students learn by trying out new concepts in the environment and modifying them to suit their needs.

Instructional level people are average performers. They can read and learn through observation, but demonstration is helpful. They can follow directions, but prefer to be shown and told how to perform. These students respond best to process teaching; i.e., by doing things with the instructor. The facilitator shows students how to perform instead of assuming they will be able to apply what's been talked about or read outside of the classroom. Once a skill has been mastered, however, the student continues to refine and apply what's been learned in the community. With training and practice, it is anticipated that the majority of these students will live independently and work competitively.

Advocacy level people function well below average in most areas of academics and daily living skills. These students require intensive instruction, frequently one-to-one. Combinations of teaching methods will be necessary to get concepts across to such students. Instructions may need to be spoken, signed, written, pictorial, combined, or conveyed through other innovative approaches. Demonstration and co-active instruction may prove effective. Process learning is a must. Many clients at this level will be able to live and work in the community with supports like attendant care, communication specialists, job coaches, supervised living arrangements, special transit.

The overriding impact of ability with regard to placement is that students who are functioning at the informational or instructional level can anticipate that they will be able to ultimately find and maintain their own jobs in the future. Those who are functioning at the advocacy level will require external placement support.

EVIDENCE OF PARTICIPATION IN WORK EXPERIENCE OPPORTUNITIES

In closing, it is the opportunities to gain work experience that seem to have the greatest impact on future success in the transition process. This includes experiences through summer work programs, weekend school-to-work programs, internships and practical, on-the-job training experiences, and employment activities in one's home and community. For this reason, it is critical that families and service providers provide as many work opportunities as possible to young people with visual disabilities.

Teachers, counselors, and parents must constantly ask themselves if they would be willing to hire the young people with whom they work. If not, they must consider how to help remediate or correct the behaviors or skills that they perceive to be deficient. If they consider the children with whom they work to be job ready, they need to help determine what jobs they could be doing and move them into positions of responsibility. It is not enough to believe in the process. Service providers and parents must believe in the product! The way to manifest this belief in the product - the competent, job ready student - is to hire blind and visually impaired youngsters. Employers must have evidence that young people with disabilities can work and there is no better evidence than a work history!

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Central Auditory Processing Disorders An Overview of Assessment and Management Practices

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Hearing is a complex process that is often taken for granted. As sounds strike the eardrum, the sounds (acoustic signals) begin to undergo a series of transformations through which the acoustic signals are changed into neural signals. These neural signals are then passed from the ear through complicated neural networks to various parts of the brain for additional analysis, and ultimately, recognition or comprehension. For most of us, when someone talks about hearing abilities, we think primarily of the processing that occurs in the ear; that is, the ability to detect the presence of sound. Likewise, when someone is described as having a hearing loss, we assume that this individual has lost all or part of the ability to detect the presence of sound. However, the ability to detect the presence of sounds is only one part of the processing that occurs within the auditory system.

There are many individuals who have no trouble detecting the presence of sound, but who have other types of auditory difficulties (e.g., difficulties understanding conversations in noisy environments, problems following complex directions, difficulty learning new vocabulary words or foreign languages) that can affect their

ability to develop normal language skills, succeed academically, or communicate effectively. Often these individuals are not recognized as having hearing difficulties because they do not have trouble detecting the presence of sounds or recognizing speech in ideal listening situations. Since they appear to “hear normally,” the difficulties these individuals experience are often presumed to be the result of an attention deficit, a behavior problem, a lack of motivation, or some other cause. If this occurs, the individual may receive medical and/or remedial services that do not address the underlying “auditory” problem.

Central auditory processes are the auditory system mechanisms and processes responsible for the following behavioral phenomena.

- Sound localization and lateralization
- Auditory discrimination
- Temporal aspects of audition including
 - temporal resolution
 - temporal masking
 - temporal integration
 - temporal ordering
- Auditory performance with competing acoustic signals
- Auditory performance with degraded signals

These mechanisms and processes apply to nonverbal as well as verbal signals and may affect many areas of function, including speech and language (ASHA, 1996, p. 41).

WHAT IS MEANT BY THE TERM “CENTRAL AUDITORY PROCESSING?”

Katz, Stecker & Henderson (1992) described central auditory processing as “what we do with what we hear.” In other words, it is the ability of the brain (i.e., the central nervous system) to process incoming auditory signals. The brain identifies sounds by analyzing their distinguishing physical characteristics frequency, intensity, and temporal features. These are features that we perceive as pitch, loudness, and duration. Once the brain has completed its analysis of the physical characteristics of the incoming sound or message, it then constructs an “image” of the signal from these component parts for comparison with stored “images.” If a match occurs, we can then understand what is being said or we can recognize sounds that have important meanings in our lives (sirens, doorbells, crying, etc.).

This explanation is an oversimplification of the complicated and multifaceted processes that occur within the brain. The complexity of this processing, however, can be appreciated if one considers the definition of central auditory processing offered by the American Speech-Language-Hearing Association (ASHA).

This definition acknowledges that many neurocognitive functions are involved in the processing of auditory information. Some are specific to the processing of acoustic signals, while others are more global in nature and not necessarily unique to processing of auditory information (e.g., attention, memory, language representation). However, these latter functions are considered components of auditory processing when they are involved in the processing of auditory information.

WHAT IS CENTRAL AUDITORY PROCESSING DISORDER (CAPD)?

CAPD can be defined as a deficiency in any one or more of the behavioral phenomena listed above. There is no one cause of CAPD. In many children, it is related to maturational delays in the development of the important auditory centers within the brain. Often, these children's processing abilities develop as they mature. In other children, the deficits are related to benign differences in the way the brain develops. These usually represent more static types of problems (i.e., they are more likely to persist throughout the individual's life). In other children, the CAPD can be attributed to frank neurological problems or disease processes. These can be caused by trauma, tumors, degenerative disorders, viral infections, surgical compromise, lead poisoning, lack of oxygen, auditory deprivation, and so forth.

The prevalence of CAPD in children is estimated to be between 2 and 3% (Chermak & Musiek, 1997), with it being twice as prevalent in males. It often co-exists with other disabilities. These include speech and language disorders or delays, learning disabilities or dyslexia, attention deficit disorders with or without hyperactivity, and social and/or emotional problems.

WHAT ARE SOME OF THE BEHAVIORAL MANIFESTATIONS OF CAPD?

Below is a listing of some of the common behavioral characteristics often noted in children with CAPD. It should be noted that many of these behavioral characteristics are not unique to CAPD. Some may also be noted in individuals with other types of deficits or disorders, such as attention deficits, hearing loss, behavioral problems, and learning difficulties or dyslexia. Therefore, one should not

necessarily assume that the presence of any one or more of these behaviors indicates that the child has a CAPD. However, if any of these behaviors are noted, the child should be considered at risk for CAPD and referred for appropriate testing. Definitive diagnosis of a central auditory disorder cannot be made until specialized auditory testing is completed and other etiologies have been ruled out.

- Difficulty hearing in noisy situations
- Difficulty following long conversations
- Difficulty hearing conversations on the telephone
- Difficulty learning a foreign language or challenging vocabulary words
- Difficulty remembering spoken information (i.e., auditory memory deficits)
- Difficulty taking notes
- Difficulty maintaining focus on an activity if other sounds are present child is easily distracted by other sounds in the environment
- Difficulty with organizational skills
- Difficulty following multi-step directions
- Difficulty in directing, sustaining, or dividing attention
- Difficulty with reading and/or spelling
- Difficulty processing nonverbal information (e.g., lack of music appreciation)

There are a number of behavioral checklists that have been developed in an effort to systematically probe for behaviors that may suggest a CAPD (Fisher, 1976; Kelly, 1995; Smoski, Brunt, & Tannahill, 1992; Willeford & Burleigh, 1985). Some of these checklists were developed for teachers, while others were designed for parents. These checklists can be helpful in determining whether a child should be referred to an audiologist for a central auditory processing assessment.

HOW IS CAPD ASSESSED?

CAPD is assessed through the use of special tests designed to assess the various auditory functions of the brain. However, before this type of testing begins, it is important that each person being tested receive a routine hearing test for reasons that will become obvious later.

There are numerous auditory tests that the audiologist can use to assess central auditory function. These fall into two major categories: behavioral tests and electrophysiologic tests. The behavioral tests are often broken down into four subcategories, including monaural low-redundancy speech tests, dichotic speech tests, temporal patterning tests, and binaural interaction tests. It should be noted that children being assessed for CAPD will not necessarily be given a test from each of these categories. Rather the audiologist will select a battery of tests for each child. The selection of tests will depend upon a number of factors, including the age of the child, the specific auditory difficulties the child displays, the child's native language and cognitive status, and so forth. For the most part, children under the age of 7 years are not candidates for this type of diagnostic testing. In addition, central auditory processing assessments may not be appropriate for children with significant developmental delays (i.e., cognitive deficits).

Space limitations preclude an exhaustive discussion of each of the central tests that are available for clinical use. However, a brief overview of the major test categories is provided, along with an abbreviated description of a few tests that are considered representative of the many tests available for use in central auditory assessments.

ELECTROPHYSIOLOGIC TESTS

Electrophysiologic tests are measures of the brain's response to sounds. For these tests, electrodes are placed on the earlobes and head of the child for the purpose of measuring electrical potentials that arise from the central nervous system in response to an auditory stimulus. An auditory stimulus, often a clicking sound, is delivered to the child's ear and the electrical responses are recorded. Some electrophysiologic tests are used to evaluate processing lower in the brain (auditory brainstem response audiometry), whereas others assess functioning higher in the brain (middle latency responses, late auditory evoked responses, auditory cognitive or P300 responses). The results obtained on these tests are compared to age-appropriate norms to determine if any abnormalities exist.

BEHAVIORAL TESTS

Monaural Low-Redundancy Speech Tests: Due to the richness of the neural pathways in our auditory system and the redundancy of acoustic information in spoken language, a normal listener is able to recognize speech even when parts of

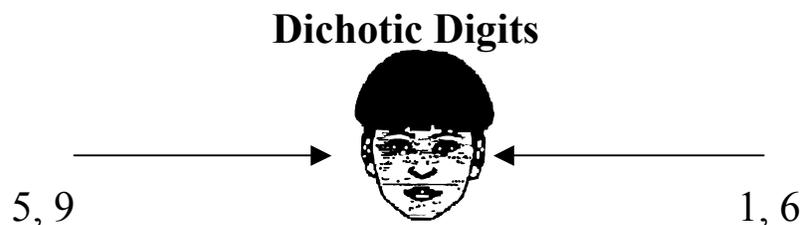
the signal are missing. However, this ability is often compromised in the individual with CAPD. Monaural low-redundancy speech tests represent a group of tests designed to test an individual's ability to achieve auditory closure when information is missing. The speech stimuli used in these tests have been modified by changing one or more of the following characteristics of the speech signal: frequency, temporal, or intensity characteristics.

An example of a test in this category is the Compressed Speech test (Beasley, Schwimmer, & Rintelmann, 1972). This is a test in which the speech signals have been altered electronically by removing portions of the original speech signal. The test items are presented to each ear individually and the child is asked to repeat the words that have been presented. A percent correct score is derived for each ear and these are compared to age-appropriate norms.

DICHOTIC SPEECH TESTS

In these tests different speech items are presented to both ears either simultaneously or in an overlapping manner and the child is asked to repeat everything that is heard (divided attention) or repeat whatever is heard in one specified ear (directed attention). The more similar and closely acoustically aligned the test items, the more difficult the task.

One of the more commonly used tests in this category is the Dichotic Digits test (Musiek, 1983). The child is asked to listen to four numbers presented to the two ears at comfortable listening levels. In each test item two numbers are presented to one ear and two numbers are presented to the other ear. For example, in figure one, 5 is presented to the right ear at the same time 1 is presented to the left ear. Then the numbers 9 and 6 are presented simultaneously to the right and left ears. The child is asked to repeat all numbers heard and a percent correct score is determined for each ear and compared to age-appropriate norms.



(For text only readers: Figure 1 shows numbers 1,6 entering the left ear and numbers 5,9 entering the right ear).

TEMPORAL PATTERNING TESTS

These tests are designed to test the child's ability to process nonverbal auditory signals and to recognize the order or pattern of presentation of these stimuli. A child can be asked to simply "hum" the patterns. In this case, the processing of the stimuli would occur largely in the right half of the brain. If on the other hand, the child is asked to describe the patterns using words; then the left side of the brain is also involved, as well as the major auditory fibers that connect the auditory portions of both sides of the brain.

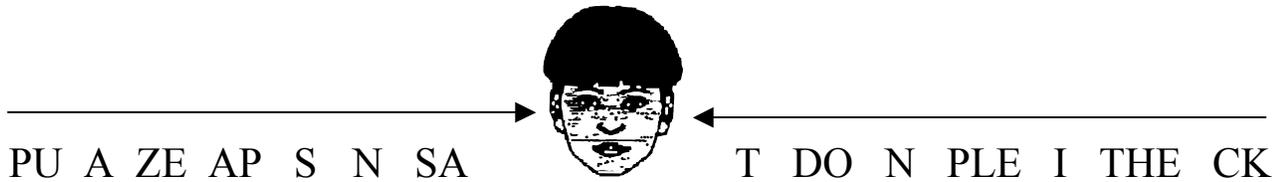
The Frequency Pattern Sequences test (Musiek & Pinheiro, 1987) is one of the temporal patterning tests used frequently with children. The test items are sequences of three tone bursts that are presented to one or both ears. In each of the sequences two tone bursts are of the same frequency, while the third tone is of a different frequency. There are just two different frequencies used in this test: one is a high-frequency sound and the other a low-frequency sound. The child therefore hears patterns, such as high-high-low or low-high-low, and is asked to either hum or describe the patterns heard. As with other central tests, the test items are presented at levels that are comfortable for the child and percent correct scores are obtained and compared to norms.

Binaural Interaction Tests: Binaural interaction tests are sometimes referred to as binaural integration tests. These tests tap the ability of structures low in the brain (brainstem) to take incomplete information presented to the two ears and fuse or integrate this information in some manner. Most of the tests in this category present different parts of a speech signal to each ear separately. If only one part of the signal is presented, the child usually cannot recognize the test item. However, if the two different parts of the stimuli are presented simultaneously, with one portion going to one ear and the other portion to the other ear, the child with normal processing abilities has no difficulty recognizing the test item. This is because the two parts (which are unrecognizable if presented in isolation) are integrated into a single identifiable stimulus by the auditory nervous system.

An example of a test in this category is the Rapidly Alternating Speech Perception test (Willeford, 1976). For this test, sentence materials are divided into brief segments which are alternated rapidly between the two ears. The example below is a rough approximation of what happens to a sentence when it is segmented in this manner. In this example, the first sound in the sentence "Put a dozen apples

in the sack” (represented by pu) is presented to the right ear, then the t sound is presented to the left ear, and so forth and so on. If the child hears only the segments presented to the right ear or left ear, he or she is unlikely to be able to recognize the sentence. However, if the right ear and left ear segments are presented in a cohesive fashion to the child, sentence recognition improves dramatically as long as this particular function of the brain is intact.

Rapidly Alternating Speech Perception



(For text readers only: Figure 2 shows a visual representation of the above example, with the letters PU, A, ZE, AP, S, N, SA, presented to the right ear and letters T, D,O, N, PLE, I, THE, CK, presented to the left ear).

WHAT ARE THE EDUCATIONAL IMPLICATIONS OF CAPD?

The list of behavioral observations provided earlier in this article highlights many of the academic and/or speech and language problems that might be experienced by the child with CAPD. Since speech and language skills are developed most efficiently through the auditory sensory modality, it is not unusual to observe speech and language problems, as well as academic problems (many of them language-based), in children with CAPD. If a child experiences difficulty in processing the brief and rapidly changing acoustics of spoken speech, he or she is likely to have problems recognizing the “speech sounds” of language. If problems are encountered in recognizing the sound system of language, then additional problems are likely to be encountered when the child is asked to begin to match “speech sounds” to their alphabetic representations (a skill that serves as the foundation for the development of subsequent reading and writing skills). This in turn can lead to comprehension problems and poor academic performance. It is worth reiterating at this time that not all children with CAPD will experience all of these problems. There is a wide range of variability in the problems experienced by children with CAPD; however, it should be recognized that the presence of a CAPD places the child at risk for developing many of these language and academic problems.

WHAT MANAGEMENT STRATEGIES CAN BE USED TO REMEDIATE CAPD?

There are several different ways to help children overcome their CAPD. The exact procedures or approaches used will depend upon a number of factors, including the exact nature of the CAPD, the age of the child, the co-existence of other disabilities and/or problems, and the availability of resources. In general, the approaches to remediation or management fall into three main categories: (a) enhancing the individual's auditory perceptual skills, (b) enhancing the individual's language and cognitive resources, and (c) improving the quality of the auditory signal.

The following discussion presents some of the procedures that may be used with a child with CAPD. More detailed information is beyond the scope of this article, but may be found in the various resources listed at the end of this article.

Many children with CAPD will benefit from auditory training procedures and phonological awareness training. Intervention may also involve the identification of (and training in the use of) strategies that can be used to overcome specific auditory, speech and language, or academic difficulties. A number of actions can be taken to improve the quality of the signal reaching the child. Children can be provided personal assistive-listening devices that should serve to enhance the teacher's voice and reduce the competition of other noises and sounds in the classroom. Acoustic modifications can be made to the classroom (e.g., carpeting, acoustic ceiling tiles, window treatments) which should help to minimize the detrimental effects of noise on the child's ability to process speech in the educational setting.

Finally, teachers and parents can assist the child in overcoming his or her auditory deficits by speaking clearly, rephrasing information, providing preferential seating, using visual aids to supplement auditory information, and so forth. The program should be tailored to the child's individual needs, and it should represent an interdisciplinary approach. Parents, teachers, educational specialists, and other professionals, as appropriate, should be involved in the development and implementation of the child's management program.

DO CHILDREN WITH CAPD HAVE HEARING LOSS?

Children with CAPD do not have hearing loss if the term is used to refer to a loss of hearing sensitivity. Most children with CAPD have normal hearing sensitivity and their auditory difficulties will not be detected during routine hearing testing

unless some of the special “sensitized” tests (see discussion above) are administered. These children, however, have hearing loss in the sense that they do not process auditory information in a normal fashion. They have auditory deficits that can be every bit as debilitating as unidentified hearing loss. If the auditory deficits are not identified early and managed appropriately, many of these children will experience speech and language delays, academic failure and/or underachievement, loss of self-esteem, and social and emotional problems.

CAN A CHILD HAVE BOTH A HEARING LOSS AND A CAPD?

Children can have both a hearing loss and a CAPD. Fortunately, most children seen for central auditory testing have normal hearing (i.e., detection) abilities. However, children with hearing loss can also have a CAPD. In fact, the presence of a hearing loss may place a child at risk for CAPD. This is because the auditory pathways and centers in the brain develop as they are stimulated with sound. The presence of a hearing loss may limit the amount and type of auditory stimulation that is necessary to promote optimal development of the auditory nervous system. If this happens, then auditory deficits are likely to result.

A question frequently asked of audiologists is “whether or not a child with a hearing loss can be tested for CAPD?” The answer is not a simple “yes” or “no.” Many children with hearing losses can be tested as long as they have some hearing (i.e., detection) abilities. Interpretation of the test results does become somewhat more difficult for the audiologist who is conducting the testing if a hearing loss is present, but there are distinct patterns of test results that can indicate the presence of a CAPD. Moreover, there are certain tests that the audiologist can use that are not affected to the same degree as other tests by the presence of a hearing loss. These tests should be used whenever feasible. Unfortunately, there are some individuals with losses so severe that testing cannot be completed. As a general rule, central auditory testing cannot be done if the individual being tested has a hearing loss falling in the severe- to-profound range.

WHERE CAN I GO FOR ADDITIONAL INFORMATION?

The books listed in the reference section are good sources of information. In addition, we have provided a list of web sites that you may find helpful.

SELECTED WEB SITES FOR TEACHERS AND PARENTS

<<http://www.kidspeech.com/tips.html>>

<<http://www.ldanatl.org/factsheets/Auditory.html>>
<<http://www.healthtouch.com/level1/leaflets/aslha/aslha024.htm>>
<http://www.ldonline.org/ld_indepth/process_deficit/table_deficits.html>
<http://www.ldonline.org/ld_indepth/process_deficit/pro_deficits.html>
<http://www.Kidshealth.org/parent/healthy/central_auditory.html>

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The Importance of Reality-Based Services

By Terry Murphy, Executive Director, Texas Commission for the Blind

In an e-mail message floating around recently was a list of things high school and college graduates “should have learned in school but didn’t.” Although the message I received attributes the sayings to Bill Gates, the more likely source of the original list is probably Charles Sykes, the author of “Dumbing Down our Kids.” I haven’t read the book, but it’s said to talk about how feel-good, politically-correct teachings have created a full generation of kids with no concept of reality and how this concept sets them up for failure in the real world.

Regardless of who wrote them, two items from the list are similar to what I’ve said to my son and daughter over the years. Item 4 says, in part, “If you think your teacher is tough, wait till you get a boss....” Item 8 says, “Your school may have done away with winners and losers, but life has not. In some schools, they have abolished failing grades; they’ll give you as many times as you want to get the right answer. This doesn’t bear the slightest resemblance to ANYTHING in real life.”

More than a few people would say these messages are too cynical or discouraging for kids, especially kids with disabilities. I think they are good, tough-love pieces of advice for every young person who has the potential of being in the job market some day. It’s true in real life, employers don’t provide unlimited opportunities for you to get the job done, and 60 may not be a passing grade.

About the same time I received the e-mail, an interesting article hit the newspaper in which Erica Goode of *The New York Times* reported on a Cornell University research project conducted by a Professor David Dunning and a graduate student.

The research found that most incompetent people do not know that they are incompetent, adding that people who do things badly are usually supremely confident of their abilities---more confident, in fact, than people who do things well. One of the reasons, Dunning says, is that honest feedback is generally absent. Social norms prevent most people from blurting out “you stink!” - truthful though this assessment may be.

The Texas Commission for the Blind comes into contact with people from all ages, all walks of life, for whom blindness is a fact. Our important job is to weave a good dose of reality into the fabric of our services lest we become guilty of encouraging false confidence and incompetence. It’s equally important, however, to be positive. This dual responsibility often requires our staff to walk a verbal tightrope as they strive to be tough, yet optimistic, and honest, yet encouraging.

Tough means saying to a teenager and his parents that blindness is not a characteristic that all potential employers understand, so he may have to work harder than a sighted person to sell himself. Optimistic means saying to them that we know two people with similar goals who six months ago went to work making a good living and one has already earned a raise. We know it can be done.

Honest means telling someone who has been blind all her life that a promotion is probably escaping her not because she is blind but because she steadfastly refuses to learn the additional skills it takes to adjust to today’s faster-paced work environment. Encouraging means telling her at the same time that thousands of people who are blind have learned braille or computer skills to boost their potential for better positions. We know it can be done.

Being tough and honest isn’t always easy. It sometimes places you at risk of being called insensitive. A parent wrote a while back to complain that his daughter’s college counselor was insensitive because the counselor had said to his daughter that she needed to be in class rain or shine. The parent was astounded that anyone would expect his blind daughter to walk to class in the rain. The counselor’s tough-love approach had been to say, “Walking in the rain isn’t my idea of fun either, but you can’t pass this course if you are not in class. Let’s see if there is an alternative route that would give you more cover to your classroom, and you might want to buy a bigger umbrella.” I’m happy to say that the loving parent and student did eventually embrace the reality that a future employer will also expect her to

come to work rain or shine. The last I heard she had really blossomed into an independent traveler (with an umbrella in her backpack).

Some of the most independently functioning people I've known in my years with the Commission have shared with me that part of their independence grew from parents who were not reluctant to lovingly expect as much from them as their sighted siblings. One friend said that when he gave in to the temptation to use his blindness to get out of household chores or school, his parents never once flinched or gave in, and he soon got the message. He said that the confidence they had in him resulted in his having confidence in himself as he conquered task by task alongside his brothers, who as typical siblings weren't exactly disinclined "to tell him it like it is."

In our business, we see the gamut of skills coming through our doors in both consumers and employees who are blind. One of the most frustrating aspects of our job is to work with an untrained, incompetent traveler and get excited about the added potential better skills would provide, only to be met with the brick wall of "I get around just fine." Equally frustrating is seeing the untapped potential of a person who refuses to see the value that braille can add to their productivity. "I never have to take the notes in meetings --- why should I learn braille?" What do you say to people like this? Yes, you're doing great? No. Avoiding reality may rob this person of his or her highest potential, so you dig deep into your bag of communication skills and find a way to be tough and honest, yet optimistic and encouraging.

All this is no easy task, but we have found that patience, understanding, and a healthy dose of reality go a long way toward replacing false confidence with competence. For those of you who may be interested in the rest of the e-mail, here's the whole list of recommendations.

MESSAGES ON LIFE

- Rule 1 Life is not fair; get used to it.
- Rule 2 The world won't care about your self-esteem. The world will expect you to accomplish something before you feel good about yourself.
- Rule 3 You will not make 40 thousand dollars a year right out of high school. You won't be a vice president with a car phone, until you earn both.

- Rule 4 If you think your teacher is tough, wait till you get a boss. He doesn't have tenure.
- Rule 5 Flipping burgers is not beneath your dignity. Your grandparents had a different word for burger flipping; they called it opportunity.
- Rule 6 If you mess up, it's not your parents' fault, so don't whine about your mistakes, learn from them.
- Rule 7 Before you were born, your parents weren't as boring as they are now. They got that way from paying your bills, cleaning your clothes and listening to you talk about how cool you are. So before you save the rain forest from the parasites of your parents' generation, try "delousing" the closet in your own room.
- Rule 8 Your school may have done away with winners and losers, but life has not. In some schools they have abolished failing grades; they'll give you as many times as you want to get the right answer. This, of course, doesn't bear the slightest resemblance to ANYTHING in real life.
- Rule 9 Life is not divided into semesters. You don't get summers off and very few employers are interested in helping you find yourself. Do that on your own time.
- Rule 10 Television is not real life. In real life people actually have to leave the coffee shop and go to jobs.
- Rule 11 Be nice to nerds. Chances are you'll end up working for one.

Champus Expands Benefits

Champus Tricare, the health insurance program for military dependents, will now cover the cost of FM amplification systems. This is a change in previous policy and is good news for those families in the military who have children with auditory impairments who would benefit from these systems. For more information, you may go to <www.asha.org/governmental_affairs/champus.htm>.

Short Classes at TSBVI Expanding

By Dr. Lauren Newton, Principal of Special Programs, TSBVI

1999-2000 SHORT CLASSES

During spring semester 2000, the Texas School for the Blind and Visually Impaired (TSBVI) offered its first academic-level short classes: Independent Living Skills (Algebra Doesn't Cook Hamburgers), which lasted for three 3-day weekends, and a one-week intensive Technology Program. Both classes were full, and staff and students alike felt that the programs were tremendously valuable. Also, we learned lessons about how to expand and improve the programs in the future. There are still many components of these programs that we want to develop as we go along.

While TSBVI summer school is primarily designed for enrichment and vocational programming, we will be offering one instructional short class during June: Adaptive Tools & Technology For Accessible Mathematics. This class is designed for secondary students who will be enrolled for credit in Algebra I or a more advanced SBOE mathematics course during the coming school year.

SOMETHING NEW ON THE HORIZON!

During the 2000-2001 school year, TSBVI will continue to offer the multiple-weekend ILS (Independent Living Skills) classes, and we will expand to two technology weeks.

In addition, TSBVI short programs will add a new model of service delivery: one week of intensive instruction that is individually tailored to the needs of each participating student. School districts, parents, and students can select content from the expanded core curriculum to be taught during this week of intensive training. For example, one student might choose to work on technology and braille, while another student might select cooking skills and Nemeth Code. TSBVI Outreach Staff will join on-campus teachers to provide instruction. Study hall will be provided during the day and evening for TSBVI staff to help students keep up with their local assignments while they are participating in this special program. The students will continue to be considered enrolled and in attendance in their local school district during the week they are at TSBVI.

The 2000-2001 TSBVI school calendar is being finalized as this issue of See/Hear goes to press. Look for the dates for all short classes on our website, or call or write Dr. Lauren Newton, principal, at (512) 206-9119, e-mail: Newton_L@tsb1.tsbvi.edu. Interested parents should talk with their local VI teachers to assist them in making a referral to a short class program.

Helen Keller National Center National Registry

By Nancy O'Donnell, Coordinator of the National Registry

Have you ever wondered how many deafblind people there are in the United States? For many years, there has been no way to answer this question for the “over 21” population other than educated guesses. Estimates have varied greatly. For example, in 1996, only 437 individuals were reported to be deaf-blind to the Rehabilitation Services Administration. On the other end of the spectrum, Schein & Delk determined that 356 people per 100,000 experience a combination of vision and hearing loss. In an effort to gain a more accurate count and an understanding of the needs of this population, the federal government recently authorized HKNC to maintain a national registry of those who are deaf-blind. We are very excited about this project!

GETTING STARTED

Over the years, HKNC has collected information on the clients we have served through our programs at headquarters, in the field, through our affiliated agencies and from other agencies or interested individuals. This information, however, has not been available on a national basis. During the summer of 1999, we enthusiastically began the process of compiling this information into a national database. Beginning with records stored in our archives, we entered data on thousands of individuals. These records include the cause of their deaf-blindness, severity of hearing and vision losses, methods of communication, residential situations, employment status and training needs. We are currently working with a programmer to combine this information into one workable database.

When this database is operational, we will have a better understanding of the numbers of people with various syndromes that cause deaf-blindness, such as Usher, CHARGE and congenital rubella. We will be able to determine the most commonly reported methods of communication, the numbers of people using

hearing aids or who have had cochlear implants, services that are available and services that are needed. All of this information will be accessible in national, state, and local profiles.

This type of demographic information is critical to agencies planning adult services for this population, to university programs preparing teachers and interpreters to work with those who are deaf-blind, to agencies providing residential and employment services, and to federal and state governments as they develop initiatives and priorities for funding.

The registry will not replace the current comprehensive system of collecting census information for children aged birth to 21, compiled by Teaching Research in cooperation with the State and Multi-State Deaf-Blind Projects. However, we will include anyone who is deaf-blind, of any age, on our registry. If you would like to register yourself or obtain an application for someone you know, you can request a copy of the registry form from Nancy O'Donnell at 111 Middle Neck Road, Sands Point, NY, 11050. Copies of the form are also available at our website: <www.helenkeller.org/national> under Special Projects – Registry.

Texas Children's Health Insurance Program (CHIP)

The federal government has made money available to states to pay for health coverage for uninsured children. This bill allows Texas to access that money by creating the Children's Health Insurance Program (CHIP), a health plan for certain low-income children. The program uses federal and state money to insure children whose families earn too much to qualify for Medicaid, but can't afford private health insurance. CHIP will provide insurance for children aged 0-19 who live in families whose income is less than 200% of federal poverty level (\$32,900 for a family of four). This will close a large gap that exists between the eligibility levels for Medicaid and the accessibility to affordable private insurance. Children of legal immigrants are also eligible for coverage. Call toll-free (800) 647-6558 for an application or more information. Applications will be able to be downloaded at <www.texcarepartnership.com> as well.

National Organization on Disability Announces Over 550 Congregations from 50 States Have Committed to Welcoming People with Disabilities

WASHINGTON, DC - The Religion and Disability Program of the National Organization on Disability (N.O.D.) announced today that over 550 congregations have signed on to the 2,000 by the Year 2000 - Accessible Congregations Campaign. The interfaith campaign, which challenges America's congregations to welcome people with all types of disabilities as full and active participants, has received pledges from congregations in all 50 states. The campaign's theme is Access: It Begins in the Heart.

The goal of the 2,000 by the Year 2000 - Accessible Congregations Campaign is to increase the religious participation of children and adults with disabilities. By joining the campaign, a congregation acknowledges that it has barriers, both physical and attitudinal, to the full participation of people with disabilities and commits to begin the process of removing them.

"We are well on the way to reaching our goal of 2,000 by the year 2000," said Ginny Thornburgh, Director of N.O.D.'s Religion and Disability Program. She added, "Ours is the only national disability program addressing interfaith issues. True religious access is about opening hearts, minds and doors to millions of Americans with disabilities who seek a full life of faith."

To join the campaign, an Accessible Congregation must commit to the following three principles:

- In our congregation, people with disabilities are valued as individuals, having been created in the image of God;
- Our congregation is endeavoring to remove barriers of architecture, communications and attitudes that exclude people with disabilities from full and active participation; and
- People, with and without disabilities, are encouraged to practice their faith and use their gifts in worship, service, study and leadership.

N.O.D.'s Religion and Disability Program, an interfaith effort, was established in 1989 to urge local congregations, national denominational groups and seminaries to

identify and remove the obstacles to worship that alienate people with disabilities. Resources available from the program include training conferences and publications such as the popular handbook *That All May Worship*, a step-by-step guide designed to help congregations to remove existing barriers. Ginny Thornburgh, co-author of *That All May Worship*, has directed the Religion and Disability Program at N.O.D. for the past ten years.

The National Organization on Disability promotes the acceptance and full participation in all aspects of life of America's 54 million men, women and children with physical, sensory or mental disabilities. Founded in 1982, N.O.D. is the only national disability network organization concerned with all disabilities, all age groups and all disability issues.

For more information about 2,000 by the year 2000 -Accessible Congregations Campaign, please contact N.O.D. at (202) 293-5960, TDD (202) 293-5968 or e-mail religion@nod.org. The committed congregations are listed by state on the Web at <www.nod.org>.

Bits and Pieces

- Do you have used hearing aids or eyeglasses? Usually, any place that sells glasses will accept old glasses (frames and lenses intact) and recycle them to people in need. Hearing aids may be sent to Starkey Hearing Foundation/Fund, 4248 Park Glen Road, Minneapolis, MN 55416 to be given to people who need hearing aids but can't afford them. Hearing aids may also be sent to Oye Amigo, Inc, Janet Kruegger, PO Box 5133, Austin, TX 78763. These hearing aids get recycled in Mexico and Central America.
- The Disability Policy Consortium (DPC) is an independent group of statewide advocacy organizations working for progressive public policy on behalf of Texans with disabilities. They have a new website, <www.dpctexas.org>. Included on the website are sections for DPC's legislative platform, summaries of proposed legislation and appropriations issues. In addition, in the top right-hand corner of the website homepage you can gain access to the "Action Alert" page. This will be used to give timely information regarding issues the DPC

feels require immediate action. This will be an important site as we enter a new legislative year.

- Kids as Self-Advocates (KASA) is a club for teens that want to be heard on issues relating to disabilities. KASA is made up of teens and young adults with special healthcare needs, as well as their friends and siblings, speaking on their own behalf. Membership is free. For more information, contact Julie Keys, KASA/Family Voices, 900 N. Franklin, Suite 210, Chicago, IL 60610, (312) 642-2745. KASA has a web page that is part of the Family Voices website, <<http://www.ichp.edu/mchb/fv/kasa.html>>.
- Specialized Telecommunications Devices Assistance Program, authorized during the 1999 Texas Legislature, requires the Texas Commission for the Deaf and Hard of Hearing (TCDHH) to provide assistance to persons with disabilities to acquire a telecommunications access device or service suitable to meet their basic needs. TCDHH will receive applications, determine eligibility, and issue vouchers for the devices or services to eligible individuals. For more information, contact TCDHH at (512) 407-3250 (voice) or (512) 407-3251 (TTY).
- Web-Braille, a new service of the National Library Service (NLS) is ready for use. Grade 2 braille books are available to be downloaded or for online use by eligible individuals, libraries, and schools with braille embossers, refreshable braille displays, and other braille-aware devices. To retrieve Web-Braille files, you can use whatever braille equipment and browser you find most comfortable. Web-Braille contains 2,672 books and is growing. To get a user ID for Web-Braille, contact the library that handles your braille magazine subscriptions. (In Texas, that is the Texas State Library, contact them at (800) 252-9605). You will be asked to select a password and provide an e-mail address. Questions? Contact Judy Dixon at jdix@loc.gov or (202) 707-0722.
- A new law gives non-English speaking parents of students with disabilities the right to have important information in their native language. From the amended Texas Education Code:

“If the child’s parent is unable to speak English, the (school) district shall:

1. Provide the parent with a written or audio taped copy of the child's IEP translated into Spanish if Spanish is the parent's native language; or
2. If the parent's native language is a language other than Spanish, make a good faith effort to provide the parent with a written or audio taped copy of the child's individualized education program translated into the parent's native language.”

- Parents may be interested in *What a Good IDEA! The Manual for Parents and Students about Special Education Services in Texas*. The manual was updated to include the final regulations from the 1997 reauthorization of Individuals with Disabilities Education Act (IDEA). To order a copy, contact either The ARC of Texas at (800) 252-9729 or Advocacy, Inc. at (800) 252-9108. Copies cost \$10 and are available in Spanish as well as English. English audio taped copies are also available. Copies are available free of cost from Texas Commission for the Blind by contacting your child's BVICP Caseworker.
- Go to <<http://www.freedomforum.org/newsstand/reports/telability/printdir.asp>> if you want to download the 1999-2000 edition of *America's Telability Media*. This 320-page book describes resources concerning access to mass media for persons with disabilities.
- Go to <<http://www.worksupport.com>> Your gateway to information, resources, and services regarding the employment of people with disabilities. This site features updates in the following areas: accommodations, bridge to employment, disability management, law and policy, supported employment, workforce diversity, and workforce training.

The Deaf-Blind Theatre Access project has a manual for making theatre accessible to the deafblind. The purpose of this manual is described as follows: “Too often, entertainment is out of reach for people who are deaf and blind (deafblind). The challenges of communication and mobility can keep deafblind people at home, isolated. Yet, with specially trained interpreters, close-up seating, and an opportunity to experience sets, costumes, and props through touch, deafblind people can experience the magic of theatre.”

- Go to <<http://www.dac.neu.edu/nuiep/tap/>> to view the manual or call the Interpreter Education Project for New England at Northeastern University at (617) 373-2463 (voice) or (617) 373-4302 (TTY).
- A new book from Pro-ED is entitled, *Finding Wheels: A Curriculum for Non-drivers with Visual Impairments for Gaining Control of Transportation Needs*. The authors, Anne Corn and Penny Rosenblum, were inspired to write this book based on the memories of being visually impaired teens who were not learning to drive at the time their peers were. They have written a book that helps teach strategies to a person with visual impairments to be a successful non-driver and maximize independence. The book cost \$34.00 and may be ordered from Pro-Ed at (512) 451-3246 or online at <www.proedinc.com>.

CLASSIFIEDS

Mail or e-mail your new classifieds to Jim Durkel at:
TSBVI Outreach, 1100 West 45th St., Austin, TX 78756, or durkel_j@tsb1.tsbvi.edu.
An up-to-date Statewide Staff Development Calendar is posted
on TSBVI's website at www.tsbvi.edu.

Texas Focus
June 14 - 16, 2000
Airport Hilton Hotel
El Paso, Texas

This conference is open to teachers, families, administrators, and others interested in the education of students with visual impairments, including those with deafblindness and other multiple disabilities.

Speakers will include Deborah Chen, Linda Mamer, Walter Ducret, and Dona Sauerburger.

For further information contact: Jim Durkel at TSBVI Outreach
Phone: (512) 206-9270
Email: durkel_j@tsb1.tsbvi.edu

Technology Week
July 25 - 27, 2000
Austin, Texas

This hands-on training will help teachers, paraprofessionals, and family members learn how to use a Braille N Speak and JAWS, access the Internet, modify augmentative communication devices for the visual impaired, produce braille, and much, much more.

Contact: Jim Durkel at TSBVI Outreach
Phone: (512) 206-9270
E-mail: durkel_j@tsb1.tsbvi.edu

12th Annual Texas Fiesta Educativa Conference
“Uniting Families, Schools and Communities”
August 25 - 26, 2000

St. Anthony Wyndham Grand Heritage Hotel
300 E.Travis, San Antonio, Texas

This two-day conference offers comprehensive topics applicable to Spanish speaking and Hispanic persons with disabilities, their families and those who serve them. Friday workshops are geared for professionals and will be conducted mostly in English. Saturday sessions are geared toward Spanish speaking parents and professionals, and will be conducted mostly in Spanish.

Interpreters will be available for both days.

A special pre-conference held on August 24, 2000 will address:
Disproportionate Representation of
Language Minority Students in Special Education Language

For information, contact Yvette Hinojosa, Director of P.O.D.E.R. at (210) 222-2637

Third Annual American Stickler Syndrome Conference

June 11 - 13, 2000

Denver Marriott Tech Center
Denver, Colorado

This conference includes information from medical professionals and others, for families and individuals involved with people who have Stickler Syndrome.

Contact: Stickler Involved People
15 Angelina, Augusta, KS 67010
Phone: (316) 775-2993

E-mail: houch@southwind.net

**AER International Conference
"AERodynamics"
July 15 – 19, 2000
Denver, Colorado**

For further information contact AER at (703) 823-9690.

**Early Connections: Developing Partnerships in Services
to Young Children with Visual Impairments**

June 4 - 8, 2000

**University of British Columbia Conference Center,
Vancouver, BC, Canada**

Target audience: Families and professionals who work with children ages birth - 8, with visual impairments, including deafblindness and multiple disabilities.

For information call: 1 (604) 822-1050,
or visit the website at

<http://www.conferences.ubc.ca/conferences/events/earlyconnections/reg.htm>

4th International Moebius Syndrome Conference

July 21 - 24, 2000

Sturbridge Host Hotel and Conference Center

366 Main Street

Sturbridge, Massachusetts

For information call (508) 347-7393

**American Association of the
Deaf-Blind Convention
July 27 - August 1, 2000
Location: Columbus, Ohio
Contact: Joy Larson (301) 588-6545**

**National Organization on
Albinism and Hypopigmentation
(NOAH)
8th Annual National Conference
July 13-16, 2000
Burlington, Massachusetts
Contact: (800) 473-2310
www.albinism.org**

**Two Dirty Words:
Planning and Organization Skills
for Students
with Visual Impairments**

August 28, 2000

Region X ESC, Richardson, Texas

**Presenters: Karen and Jay Stiteley
Contact: Kitra Hill Gray
(972) 348-1580**

**Position Available: Teacher in Special Programs
Texas School for the Blind & Visually Impaired**

Responsibilities: Participates with other staff in the TSBVI Special Programs Department, other departments across campus, and local districts, to develop programs for and provide instruction to students across Texas through an on-campus, short-term model. Programs include short classes provided during the school year and during summer school.

Qualifications: Has or is eligible to receive Texas teacher certification with an endorsement in Visual Impairment; at least two years experience working as a teacher of students with visual impairments; strong ability to work well with other professionals and with parents; good planning and organizational skills; experience serving visually impaired students in the public schools in an itinerant model is preferred; experience working with students who have academic abilities at various grade levels and providing instruction in a range of disability-specific curricular areas is also preferred. This position will begin August 2000.

**For more information, contact:
Dr. Lauren Newton, Principal of Special Programs
Phone: (512) 206-9119
Email: Newton_L@tsb1.tsbvi.edu**

Get On the List!

As you may recall, we have been counting down to the launch of our new mailing list database. This is the first newsletter to be mailed out on this database, and it is likely that some people neglected to send in their updated mailing list. Last fall we sent letters to the more than 7,000 people on our mailing list, asking those who were interested in continuing to receive SEE/HEAR (and other mail-outs) to complete and send in a mailing list update form. Our revised mailing list currently contains the names of just over 1,900 people. You do the math; that's a big difference!

Please check with the families and professionals you know who normally receive the newsletter to make sure they have this edition. If not they are probably not on our new mailing list. If they have simply forgotten to send in their mailing list update for SEE/HEAR and would like to receive it, have them complete **the form that follows** and mail it in to us at TSBVI Outreach. Please feel free to photocopy this form to share with as many others as you like. The form is also accessible on our website at <www.tsbvi.edu>. Please help us connect with those who want to receive SEE/HEAR and tell them to get on the list!

Texas School for the Blind and Visually Impaired Outreach Program Mailing List

The Outreach Program at TSBVI regularly sponsors conferences and workshops on subjects related to parenting or providing services to children and youth birth to 22 years old with visual impairment (alone or with other disabilities) and deafblindness. The Outreach Program also publishes SEE/HEAR, a quarterly newsletter with timely information on these topics. If you wish to be on our mailing list, please fill out this form.

All blanks not marked optional must be filled out or you will not be put on the mailing list!

Name:

First: _____

Last: _____

Agency name: _____ (Optional, but must be filled in if no individual is designated to receive this information.)

Year round mailing address:

(street) _____

(apt.) _____

(city) _____

(state) _____

(country if outside of US) _____

(zip code) _____

Is this address a work address? (circle) Y N

Phone numbers (optional)

Work: _____

Home: _____

Fax: _____

E-mail address (optional): _____

School district (optional): _____.

ESC Region (circle): 1 2 3 4 5 6 7 8 9 10
11 12 13 14 15 16 17 18 19 20

Title (must circle at least one; ran circle more than one)

Family member (relationship to child _____) Community member, Consumer, Parent support staff (i.e., PATH, Pilot Parent, etc.)

AI teacher, AT specialist, Deafblind teacher, ECI interventionist, ESC consultant, General education elementary, General education secondary, Headstart teacher, Inclusion teacher, PPCD teacher, RDSPD parent advisor, Resource room teacher, Self-contained special education teacher, Technology teacher, University staff, VI teacher,

Audiologist, COMS, Counselor, Diagnostician, Medical doctor, Nurse, OT, Psychologist, PT, Social worker, Speech language pathologist,

Brailist, Interpreter, Intervener, Paraprofessional

Director of special education, Principal, RDSPD director, Supervisor, TEA specialist

BVICP, Deafblind specialist, Home support provider, Rehab counselor, Rehab teacher, Respite provider State program administrator, Transition specialist,

Advisory board member, Legislator, Outreach specialists, School board member

Reading medium: (circle one)

print (English)	web (English)	disk (English)
braille (English)	large print (English)	audio (English)
print (Spanish)	web (Spanish)	disk (Spanish)

**Mail this form to:
TSBVI Outreach
1100 West 45th Street
Austin, TX 78756
Attention: Mailing List**

SEE/HEAR

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Contributions to the newsletter are always welcome.
Articles can be mailed or e-mailed to section editors at:

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Austin, TX 78756

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Deadlines for articles are:
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March 1st for the Spring edition
June 1st for the Summer edition
September 1st for the Fall edition

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The audio version of SEE/HEAR is provided by
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SEE/HEAR is available in Spanish and English on TSBVI's website at <www.tsbvi.edu>.

If you no longer wish to receive this newsletter, please call (512) 206-9314.

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