

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 and Texas Commission for the Blind

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Kate's Corner

I hope all of you are enjoying the easy pace of summertime. The folks here at Outreach are taking some time off in July for vacations, so we decided to replay some of our favorite articles in this edition. These articles come from past SEE/HEAR, P.S. NEWS!!! and VISIONS newsletters. Many of them are available in English on our website, but have not been available in Spanish. Some of these have never been included in the archives in either English or Spanish. We hope those of you who have read these before will benefit from a second read, and those of you who have never read them will find them interesting. Look for more reprinted articles in future issues of SEE/HEAR.

Kate's Corner - continued on page 2

Kate's Corner - continued from page 1

One member of our Outreach staff will be extending her vacation this year. Millie Smith has decided to retire and start traveling outside of Texas for a while. I will miss Millie's wit and wisdom while she's away, but I know we can lure her back now and again. Call it denial, but I predict we haven't seen the last of her, and I am so glad. Millie has made a significant contribution to children with visual impairments in Texas as well as many of the professionals serving these children. Those of us who have had the privilege to work with Millie know that she has a true passion for helping these children achieve satisfying and successful lives. Her work in the classroom, as an Outreach consultant, as an author, and as an advocate attest to this passion. All of us in Outreach wish Millie a bon voyage and many good adventures this next year.

It is with sadness that I mention the passing of two friends of the deaf-blind community, Dennis Richardson and Pete Palasota. Dennis was one of the first children I taught who was deafblind. Actually, he was the teacher, and I was the pupil. Pete Palasota, another of my teachers, was father to Chris and Jason, husband to Sheryl and a strong advocate for people who are deafblind. I'll miss them both.

You will find our annual SEE/HEAR survey inserted in this edition of the newsletter. Please help us by taking time to complete the survey and return it to us. We read each and every one and use this information in planning new editions. You can also use this form to notify us of a change of address or even to tell us you don't want to receive the newsletter anymore.

Inclusion in Church Communities

By Mel Dugosh, Parent, Pipe Creek, Texas

This article first appeared in the Fall 1997 edition of SEE/HEAR

In 1995 I attended a conference sponsored by C.A.M.P., Children's Association for Maximum Potential, and moderated by the editor of Exceptional Parent magazine. The conference objective was to improve relationships between parents of children with significant disabilities and medical and educational professionals. After ten years of parenting one child, I admit that I had become very cynical that those relationships could do anything but worsen.

The workshop was dry and predictable with the professionals extolling their expertise and the parents participating little. Suddenly a male parent stood and said, "Hey, let's talk about what's really bothering me ... we can't even go to church as a family anymore ... our child isn't welcome there. When we find a church that wants all of us ... this is where we are going to go."

The meeting went haywire, with the parents all speaking at once ... out loud and amongst themselves, each of them sharing a story of exclusion at the hands of a church. I said nothing; this hardened parent had dissolved in tears, silently grieving the church I had lost. This was the church that had asked us to stand in the lobby during a song because our son was disruptive; the church that was not able to provide child care in the nursery because of his special needs; the church I took my son to for healing, and they "cast the devil out of him". This huge famous church that showcased its deaf ministry and occasionally proudly handed over its pulpit to an evangelist with cerebral palsy, had no room for our tiny lovable son, Chris, who was born with blindness and deafness but sees and feels what most of us cannot. Our son, Chris, who without hands somehow manages to touch us with warmth each day.

It had been the ultimate rejection, the rejection that I had not allowed myself to even think about; it suddenly seemed that it was not that uncommon. For months after the meeting I wondered about other parents and their church experiences. Eventually, with the help of C.A.M.P. and their agency's commitment to the many aspects

of the physical and psychological needs of both the child with disabilities and the entire family unit, I launched a very unscientific qualitative survey to discover if in fact other families with children like mine were finding a policy of exclusion in their community churches.

FIRST RESPONSES

The research indicates that when a child with significant disabilities is born into a family the initial contacts for assistance are within the immediate family, the medical community, and their church community. These crucial "first responses" to what the family may perceive as a crisis situation seem to set the tone for their interactions with government and community resources that will follow.

The historical legacy of placing persons with significant physical and mental disabilities in institutions or segregated in their homes may be a contributing factor to the hostile atmosphere that some of the survey respondents found. They initially sought comfort and guidance in their local church community and were met with blame, accusation and rejection.

PRESSURE FOR COMPLIANCE

In several denominations, instances were reported where new families having a child with physical disabilities and/or mental disabilities with no previous advocacy training or experience with community inclusion heard doctrines of "retribution" and felt pressure to "repent" and "seek a healing" for their child. A parent responded, "I somehow felt that I must apologize to the congregation because my child with mental disabilities and an ongoing chronic illness, did not have a complete recovery, or even close, as if my faith wasn't strong enough to receive a healing from God for my child."

Results reported from these types of incidences yielded emotional distress, anger at God, withdrawal from church and community, and reluctance to discuss these happenings.

DENIAL

It is not uncommon for parents dealing with difficult circumstances to keep their thoughts and emotional pain to themselves. Not saying anything or saying very little protects them against vulnerability. A parent remembers, "My son's Down Syndrome was not obvious in his appearance for the first few months after his birth. Our church was so large that many people did not know that my husband and I were dealing with the initial pain and shock of the news ourselves. The problem was that I wanted to continue keeping his Down Syndrome a secret. I wanted everyone to think of me as a happy and fulfilled new Mom and not feel sorry for me. While I continued this 'happy face,' inside I felt as though I was surrounded by a huge dark cloud of despair, and it was many months before I was even ready to face the reality or even admit to anyone that there was a problem."

Parents that are not openly expressive and are not exhibiting sadness in more obvious situations can also be perceived by those in the church community as having already successfully dealt with their circumstances. A parent expressed his thoughts in this way: "I was alone those first few days after our child with disabilities was born. Friends and relatives came to visit my wife in the hospital, they hugged, talked to her and cried with her. Our pastor and his wife came and spoke to my wife, but he did not speak to me."

GRIEF PROCESS

People may have difficulty getting through the stages of grief because they are not aware of the nature of those stages. These natural stages may contribute to church communities' inability to assess the situation and provide assistance. "After caring for my child with disabilities alone for many years I know that I need God's

strength to continue. I also know that I need the help of our entire congregation. How do I tell them now, that I, alone, am not equipped."

ANGER

Vague and undefined anger is common. Parents may become easily upset and frustrated and have no focus for their anger. These feelings of isolation and anger can be devastating. One parent described her feelings as, "...intense humiliation, guilt, condemnation, hopelessness, confusion, fear, lack of purpose for living, deep depression and despair, distrust for those in the medical profession, abandonment, and betrayal by God."

Many people were not aware of how their beliefs about God could relate to the birth of their child with mental and physical disabilities. Struggling with an unshakable image of God from their own past, while coping with an overwhelming situation, can be especially difficult. Parents dealing with these intense emotional issues need a safe and secure environment within their church community to explore their anger and other emotions, especially the anger directed specifically at God.

ACCEPTANCE

When family members reach the point in the grieving process where they are able to accept their circumstances, they begin a tentative move in a positive direction. When the family no longer sees the child's physical or mental limitations as a source of shame or as something they must overcome, and can accept that it is okay to be a person with disabilities, this is the beginning of advocacy efforts for inclusion in all aspects of community life on behalf of their child and other children with disabilities. A parent explains, "Our family is currently looking around, again, for a church. It is so difficult for us to find one where we feel that we belong. Sometimes I go scope them out by myself on Sunday, just to see if the church has others with disabilities and how they treat them. I am no longer willing to allow my child to be hurt by an uneducated church."

ADVOCACY EFFORTS

Once parents of a child with physical or mental disability become empowered to advocate for their child within their church community, humanity cries out for a new vision. Inclusion spreads throughout the community as a whole, as shown in this example from a parent: "At one time we wondered how our new baby daughter would suffer from having a brother who, because of his disability, would restrict her life and embarrass her in front of her friends. Those nightmares of the past will never come true! I now speak to other parents, professionals, the Chamber of Commerce, school boards, churches, organizations and public officials. I'm no longer ashamed, I have knowledge and confidence, and I plan to continue my work in advocating for my son and others with disabilities."

ACCESSIBILITY

If barriers of attitude, communication, or architecture exist for anyone, the foundation of the House of God is weakened for all. Inclusion in the church community will become a reality when parents of children with disabilities and adults with disabilities determine that they deserve the opportunities to achieve whatever is possible, despite the difficulties. "The church needs to provide the parishioners guidance on how to 'include' children with disabilities with their dignity intact, in the church as well as the community."

Americans with disabilities have the right to attend the church, synagogue, meeting house, mosque, or temple of their choice. However, this may mean negotiating stairs or narrow doorways, print media that is too small to read, inadequate sound systems, and bathrooms that are not accessible.

The Americans with Disabilities Act (ADA) was signed into law on July 26, 1990. This sweeping civil

rights law provided a national mandate for the elimination of discrimination against individuals with disabilities in employment, state and local government services, public transportation, public accommodations, and telecommunications. A religious entity, however, is defined under the ADA as a "religious corporation, association, educational institution, or society." Using this interpretation, church congregations, camps, church offices, and other church facilities fall within this ADA definition.

Religious organizations or entities, including places of worship, are exempt for any Title III public accommodation requirements of the ADA. Even when a religious entity carries out activities that would otherwise make it a public accommodation (for example, a restaurant, a place of lodging, a theater, a library) the religious entity is entitled to the exemption from the ADA coverage. If a church entity operates a public nursing home, day school, child care facility, and summer camp, those operations, again, are not subject to the ADA's public accommodation requirements. This also applies to religious institutions led by lay boards. The test is whether the religious entity controls the public accommodation, not who receives the services. However, a church facility operating as a profit-making, noncharitable institution does not qualify for the religious exemption.

A church can provide a daycare and avoid these issues by choosing to lease the space to a nonreligious organization that will operate the public accommodation. The tenant then becomes responsible for compliance with the ADA, not the church leasing the facility.

If a church service organization operates with assistance of federal money, the shelter will be required to be accessible to people with disabilities under section 504 of the Rehabilitation Act of 1973. Section 504 prohibits discrimination against persons with disabilities by entities receiving federal financial assistance.

The First Amendment provides, "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof..." The Supreme Court has interpreted these words to mean that government entities - federal, state and local - must avoid activities which advance or inhibit religion. Under the Supreme Court's Lemon test, named for the case in which it was adopted [Lemon v. Kurtzman, 403 U.S.602(1971)], the federal government may fund a religiously-affiliated program that 1) has a secular or civic purpose; 2) has a principle or primary effect that neither advances nor inhibits religion; and 3) avoids fostering an excessive government entanglement with religion. The broad latitude afforded by the Lemon test for federal funding of churches' nonsectarian social programs can allow for federal support for religiously affiliated programs in the areas of housing, child care, nutrition, health, inclusion, drug intervention and assistance for the poor.

ADULTS WITH DISABILITIES

An adult with mental disabilities expresses herself in this way: "Not only do people with physical disabilities get shunned, but people with [other] disabilities do as well. Many 'mega churches' define your personal success by the job you hold or the social circles you fit into. Churches make a glaring and condescending spectacle of people who think differently than they. Many times it is assumed that we are stupid and are seldom called upon to fulfill meaningful roles in church life."

"In Austin, Texas, my former 'mega church' was called upon to bake cookies for a Christmas party at the Austin State Hospital. They flatly refused. This church is approximately two blocks from the hospital and has had no known ministry to a 'community' that were truly its 'neighbors.' The good news is that the church recently issued an apology. They have become interested in the folks over at the hospital and have begun to minister to them and welcome them into the congregation."

Many parents of children with disabilities report that they converted to different denominations or left churches with policies of exclusion to join churches with visible adult congregates with disabilities. These

churches had already begun paving the way to inclusion in that church community.

DIVERSITY

A parent of a child with mental disabilities describes his new church in this way, "Our church is represented by extremely diverse personalities and backgrounds. Yet we are united into a close knit group because of God's gifts of help and hospitalities. God has blessed our congregation with many that need special accommodations, and He has given us the tenderness to understand and provide for these needs."

Looking past impairment to discover the unique gifts and potential of those who live with mental and physical disabilities is a celebration of life. This celebration, rather than the segregation of diversities, allows for the threads of interaction to become reinforced into the fabric that holds the church community together. Repeating and patterning these actions can serve as an example to the surrounding communities' increased awareness and acceptance of community inclusion.

THE FULL CIRCLE

In many communities the church is among the few viable indigenous social organizations committed to fostering the development of individuals, families and the community as a whole. There are, in fact, church leaders with or without disabilities, who are creating new inclusive church communities across America. Some have taken forthright measures and thoughtfully improved their buildings and programs. In so doing, many people have come to recognize the gifts which persons with mental and physical disabilities bring into the church community. A parent describes the programs in her church community, "Our church now has a Ministry for Special Needs with a council for fourteen people. We have a director of programs which coordinates the Sunday School programs. There are two special classes for children and one for adults, as well as mainstreaming for those higher functioning individuals. There is an interpreter for individuals who are deaf at worship and in Sunday School. We have plans for programming during family night activities on Wednesday evening during the school year, and our future goals include respite services."

"We also have an outreach for residents of several group homes and institutions in the area. We have coordinated transportation with congregates who live nearby. We recently contracted with a nonprofit agency to provide after-school care for children with special needs of elementary school age, and are hoping that some of these children will bring their families and become a part of our growing ministry."

As social injustices, ignorance and apathy are replaced with increased sensitivity and warm acceptance, the church community will begin to fully appreciate the contributions that persons with mental and physical disabilities present. In addition, their virtues of courage, patience, perseverance, and compassion can serve as an inspiration to all those in the community.

RESOURCES

National Organization on Disability
Religion and Disability Program
16th Street, N.W.
Washington, DC 20096
voice: (202) 293-5960; TTY: (202) 293-5968

Union of American Hebrew Congregations
Liheyot Advisory Committee
5th Avenue
New York, NY 10021-7064
voice: (212) 249-0100

National Catholic Office for Persons with Disability
P.O. Box 29113
Washington, DC 20017
voice: (202) 529-2933; TTY: (202) 529-2934

Editor's note: You may contact Mel at (830) 510-4495, write to Rt. 1, Box 1416, Pipe Creek, TX 78063, or e-mail to MelDugosh@aol.com.

Where Are the Parents?

By Sue Stuyvesant, Parent

Reprinted with permission from the Forgotten Kids webpage

<<http://www.mindspring.com/~l-mills/writing.html>>

Hey everyone. For those of you who don't know me (I'm only an occasional poster) I am mom to Michelle, 9 years old, microcephalic, athetoid/spastic CP, cortical visual impairment, seizure disorder -- and CUTE! OK, now for the reason I'm posting.

To make a long story short, earlier this week a question was asked by some nitwit official as to why there weren't more parents (of special needs kids) involved in the local PTA and other issues that have come up that directly involve our kids. His question, which was passed on to me was, "Where are the parents?" I went home that night, started thinking - and boy was I pi**ed - and banged this "little" essay out the next day on my lunch break. By the way, I took copies of this to the school board meeting that night, gave it to a couple of influential people and it WILL get around.....

Where are the parents?

They are on the phone to doctors and hospitals and fighting with insurance companies, wading through the red tape in order that their child's medical needs can be properly addressed. They are buried under a mountain of paperwork and medical bills, trying to make sense of a system that seems designed to confuse and intimidate all but the very savvy.

Where are the parents?

They are at home, diapering their 15 year old son, or trying to lift their 100 lb. daughter onto the toilet. They are spending an hour at each meal to feed a child who cannot chew, or laboriously and carefully feeding their child through a g-tube. They are administering medications, changing catheters and switching oxygen tanks.

Where are the parents?

They are sitting, bleary eyed and exhausted, in hospital emergency rooms, waiting for tests results to come back and wondering, "Is this the time when my child doesn't pull through?" They are sitting patiently in hospital rooms as their child recovers from yet another surgery to lengthen hamstrings or straighten backs or repair a faulty internal organ. They are waiting in long lines in county clinics because no insurance company will touch their child.

Where are the parents?

They are sleeping in shifts because their child won't sleep more than 2 or 3 hours a night, and must constantly be watched, lest he do himself, or another member of the family, harm. They are sitting at home with their child because family and friends are either too intimidated or too unwilling to help with child care and the state agencies that are designed to help are suffering cut backs of their own.

Where are the parents?

They are trying to spend time with their non-disabled children, as they try to make up for the extra time and effort that is critical to keeping their disabled child alive. They are struggling to keep a marriage together, because adversity does not always bring you closer. They are working 2 and sometime 3 jobs in order to keep up with the extra expenses. And sometimes they are a single parent struggling to do it all by themselves.

Where are the parents?

They are trying to survive in a society that pays lip service to helping those in need, as long as it doesn't cost them anything. They are trying to patch their broken dreams together so that they might have some sort of normal life for their children and their families.

They are busy, trying to survive.

Sue Stuyvesant 10/15/96: Permission to duplicate or distribute this document is granted with the provision that the document remains intact.

He's Not Crazy, He's My Husband

By Leslie Fansler, Wife, Mother, and Educator, Amarillo, Texas

This article first appeared in the April 1995 edition of P.S. NEWS!!!

Editor's note: The Fabulous Fansler family lives and works in Amarillo, Texas. Leslie sent this article to me just after Christmas vacation. I think that many of our readers will appreciate the humor and courage it takes to include a child with deafblindness in some of the "normal" activities of family holidays and vacation time. I think you will see that when the whole family makes a commitment to sharing the experience, it can happen. These events may not be without their moments, but I think it is important to remember, from these moments come some of our best memories. Contact Leslie and Keith at <fanfam@arn.net>.

My husband, Keith, and I have always enjoyed snow skiing. We started taking our oldest son, Chance, when he was five. It is an activity that we enjoyed as a family. My sister often skis with us. Our youngest son, Preston, who is deafblind, had ridden snowmobiles with us, but had not been on skis. Keith has always planned for Preston to learn to ski just like his brother, Chance, did. I thought this was a very unrealistic dream on my husband's part.

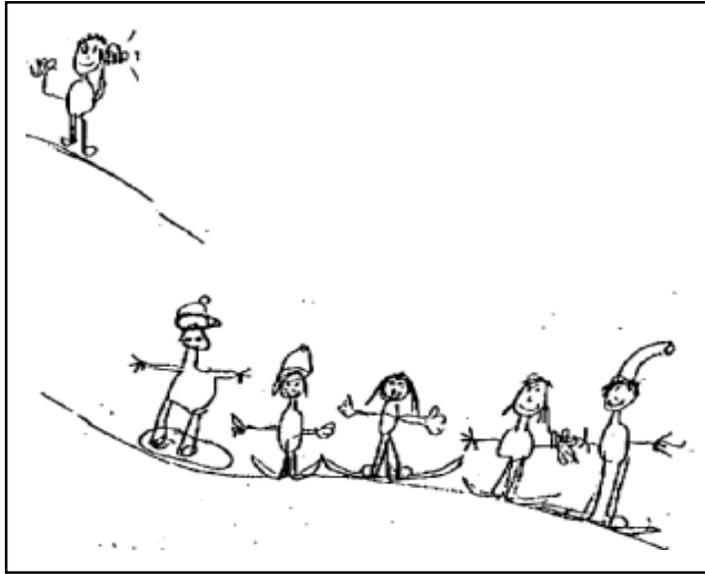
This year my mother-in-law suggested that we spend Christmas in Red River, New Mexico. We all loved the idea. By the time we left Amarillo for Red River our Christmas trip included members of my family as well as members of my husband's family. Keith had already decided that this was the year for Preston to ski for the first time. I tried to explain to him how crazy this idea really was, but Keith just ignored me!

It took the help of two grandmothers, an aunt, a great uncle and one grandpa (with camcorder in hand) to get us all on skis. Preston took these preparations well. Ski boots are very difficult to walk in. Preston, however, thought they were funny, and I was beginning to think that we could actually do this.

We put Preston's mittens on as we headed to the ski lift, and he started complaining. He became more unhappy as we rode up the mountain. We skied over to a second lift. Chance was falling with every turn and Preston was crying loudly. When we arrived at the second lift I told Keith that we had to give this insanity up. We all got on the second lift and started up to the top. I said a prayer as my sister started giving Chance some pointers on turning. Halfway up Preston got his glove off (finally) and threw it off the ski lift. Then he pulled the other glove off and Keith managed to save it. Preston's whole attitude changed immediately.

By the time we were ready to ski down, he was laughing. I guess he just didn't like gloves, even though he soon had the coldest hands on that mountain. As the day passed we all had a blast and became exhausted. Chance took a class and learned how to turn. Preston started moving his legs back and forth to slide his skis. I was proud of my family. I was also happy that we had found another normal family activity that Preston could be included in.

After we finished up for the day and were preparing to return to our hotel, a man commented to me that Preston was “a tired little boy, he was sleeping sitting up!” It occurred to me that he had not realized that Preston was blind. He thought we were just another regular family out snow skiing with our sons. Boy, had we pulled the wool over his eyes!



“Our whole skiing family lined up together. A man took our picture! The next day my Me-ma bought it!”

Original illustration by Chance Fansler

An E-Mail from Bob

Editor’s note: I recently received this e-mail, and I thought I should share it. Then I remembered one of my favorite articles from Tanni Anthony, who is the Project Director of Colorado Services for Children with Deafblindness, and thought it would make a good companion piece. I know that most parents really struggle to get their children to wear glasses and hearing aids. It’s difficult when they are babies, and when you get past that hurdle they are up and moving and throwing them out the car window. After that comes middle school and high school, where “cool” becomes a reason for not wearing them. It is important to remember when you are struggling with your child, that glasses and hearing aids are just as important as computers, braille, canes, sign language or other adaptive devices that help your child succeed in school.

“I have found the best way to encourage your children to wear glasses is to wear them yourselves if you need them. My daughter is very nearsighted and went several years avoiding wearing her glasses. She lost two or three pair. And then I went to the eye doctor and was prescribed bifocals. After a couple of months, I was wearing them all the time and made a point of always having them on at home around her. I told her my glasses helped me out at work, and I would bet hers would help her at school. Before long she was wearing them to school everyday and within a month she was wearing them all the time. She is now 20 and is never seen without her glasses on. So, if you need glasses, wear them and your kid will probably follow your example.”

Guidelines to Parents on Introducing Glasses to Young Children

By Tanni Anthony, Project Director, Colorado Services for Children with Deafblindness

Reprinted from VIP Newsletter, September 96, Volume 12, Number 3

Published Quarterly by The Blind Children's Fund

The experience of learning that your child needs glasses can be an emotional one. It is not always easy to learn that your little one will be wearing glasses. The good news, however, is that glasses can make a positive difference in your child's eyesight. This is very good news as it means that your child will have an opportunity to expand his or her world, a chance to see better, and get information in a more efficient manner. Over the years of working with families, the following ideas have been presented as helpful guidelines to parents on the process of introducing glasses to their young child. As far as new glasses are concerned, there are two critical components to check before you begin the process of encouraging your child to wear them.

PROGRAMMING

1. The frames must fit correctly. Some glasses, especially those for aphakia (eyes without lenses due to cataract surgery) can be heavy for young children. The style of the glasses will be important and you may choose a head strap to help evenly distribute the weight of the lenses. Be sure that the glasses do not pinch the child's nose or ears. Monitor the fit to be sure that there are no red marks which may eventually turn into a skin irritation.

2. The lenses must be the correct prescription. An inaccurate prescription is a common problem, but one that should be assessed, if the child does not tolerate wearing the glasses. To have the prescription checked, take the glasses to the optician or the eye doctor who can determine the optical accuracy of the prescription in the lenses against the perspective needs of the child.

Most children will accept their new glasses once they learn that the world looks better to them with the glasses than without the glasses. The goal is to provide them with enough wearing experience that they have an opportunity to discover this information. Recommendations about new glasses include the following guidelines:

The only hands that put on and remove the glasses should be adult hands.

If the child takes them off, be sure that you put them back on; and when appropriate, you take them off. As soon as the child learns that (s)he has control over the glasses, you may lose the battle. Eventually your child may have the maturity to take over this responsibility, but in the beginning it is better to have adult control so that the glasses do not become a plaything or an attention-getting tool.

Begin with small increments of wearing time and gradually build up the child's wearing tolerance.

Choose a time when the child is rested and in a good mood. Be prepared to "tap dance" a little while to keep the child occupied long enough to distract him/her from removing the glasses. Select a highly motivating activity that the child enjoys when introducing the glasses. When the child removes the glasses, stop the activity. Resume the activity when the glasses are back in place.

Make the glasses part of the child's daily routine.

Put them on in the morning as you dress your child and take them off before nap time and bedtime. This is a nice area to explore as far as using the small increments of time. For example, begin with putting the glasses on in the morning as part of the dressing routine and keep them on for as long as the child tolerates, then build to a longer period of time the next day.

See how it goes, be patient but firm.

Looking at Self-Stimulation in the Pursuit Of Leisure or I'm Okay, You Have a Mannerism

By Kate Moss, Family Support Specialist
and Robbie Blaha, Teacher Trainer, TSBVI, Texas Deafblind Outreach

This article first appeared in the July 1993 edition of P.S. NEWS!!!

Leisure time, the time free from work or duties, is important to all human beings. Leisure time is the time for doing something that will relax us or energize us so that we can renew ourselves to face the demands of our lives. It is something we require as much as food or sleep to stay healthy and sane.

We all have different ways of spending our leisure time. What might be a leisure activity for me (reading a mystery) might not be leisure for you. We know and accept this about each other. When considering "leisure skills" for children with deafblindness, however, we often focus on activities that do not relax or positively energize them. We spend their time getting them to participate in "play work" as one young man with deafblindness terms it. Learning to play games, participate in arts and sports activities, or other pursuits as a part of their educational programming may be beneficial for children in many ways, but these activities don't necessarily meet their needs for "leisure".

The type of activities that often do provide relaxation or amusement for these individuals includes behaviors that we find unacceptable: flicking your hand in front of your eyes, pulling threads out of your clothes, making repetitive sounds, etc. These behaviors are considered self-stimulation, and as such are often perceived negatively because they do not look "normal", may interfere with learning and can often become self-injurious. Yet these behaviors serve a positive purpose for these individuals as well.

Changing our perception of these self-stimulation behaviors may be the most reasonable course to take in addressing this issue. This is especially true if a change of perception also helps us find ways to give more information to the child who is deafblind and consequently reduce his need to find stimulation on his own. These behaviors may also hold the key to information about his/her personal preferences which we may tap into to select more appropriate choices for typical leisure options.

STIMULATING EXPERIENCES

Most of our "leisure activities" are nothing more than self-stimulation behaviors that have become highly ritualized over time and made socially acceptable. There is nothing intrinsically valuable or reasonable about leisure pursuits such as bungee jumping, playing cards, dancing, playing video games, listening to music, smoking, etc.

People participate in different activities because they find them to be pleasurable and because the activities alter their physical state. Each of these activities provides us with a particular type of sensory input. (See **Chart - p.12**) There is not necessarily a great difference in so-called self-stimulation behaviors and some of these activities beyond the fact that some are more socially acceptable and "normal" in appearance than others. For example, what is really so different about banging a table and banging a drum, rocking to music and rocking to silence, making repetitive sounds and imitating bird calls, spinning for no apparent reason and spinning in a ride at the amusement park?

Each day a good portion of our energies is spent in self-stimulation. Just look at the people around you. You are in a room with your family watching television or at a meeting with a group of co-workers. Although you are seemingly engaged in the same activity, your daughter or colleague is playing with her hair. Your son or your office-mate is shaking his leg and tapping out rhythms on the arm of the chair. Your husband is flipping channels with the remote or your boss is flipping papers. If you ask them what they were doing, they will

likely reply that they are watching television or having an important meeting. They will be less likely to say they were channel surfing, twirling their hair, practicing the drum part for “Wipe Out”, or fanning their papers.

Chart - Our brain seeks out stimulation through the channels of our senses. Each of us seeks out this stimulation in a variety of ways. Society accepts some of these behaviors without question, yet feels very differently about others. In some cases acceptance seems to be arbitrary. This chart shows examples of how individuals typically fulfill the craving for stimulation and how some self-stimulation behaviors of children with deafblindness parallel these behaviors.

PROGRAMMING

Sensory Channel	Miss Manners Guide to Appropriate Self-Stimulation	Creative Variations Which May Plug You Into a Written Behavior Plan
<u>Tactile</u> : information received by touch (throughout the body surface) includes sensitivity to light touch, pressure, pain, and temperature	Twirling hair, drumming fingers, playing with condensation on a drinking glass, fingering fabrics, rubbing eyes, pulling on beard	Pulling hair, lying in front of the air vent, slapping face/ear, playing with spit, rubbing your head
<u>Proprioceptive</u> : information about the relative positions of parts of the body; information comes through sensations arising in the muscles, joints, ligaments, and receptors associated with the bones	Snuggling in quilts, cracking knuckles, jiggling/crossing legs, sitting on your leg	Burrowing into furniture, wrapping arms inside tee-shirts, wrist flapping
<u>Visual</u> : information received through the eyes/seeing	Gazing at your fingernails/hands/rings, watching television without the sound, window shopping, flipping through magazines, eye pressing	Flicking hand in front of eyes, flipping pages of books, light-gazing, playing with transparent or shiny objects, eye poking
<u>Auditory</u> : information received through the ear/hearing	Humming/whistling, tapping a pencil on a surface, playing background music	Vocalizing or making sounds, banging on objects, tapping objects together next to ear
<u>Olfactory</u> : information received through the nose/smelling	Wearing perfume, sniffing magic markers/scratch and sniff stickers, burning incense	Rubbing feces on the body and smelling, smelling other peoples' hands or shoes
<u>Gustatory</u> : information received through the tongue & lips/tasting; closely tied to the sense of smell	Chewing flavored toothpicks, sucking on mints/hard candy, smoking, chewing on hair, sucking on pens/jewelry	Mouthing objects, chewing on hair, sucking on fingers, licking objects
<u>Vestibular</u> : information received through receptors in the inner ear that enables us to detect motion, especially acceleration and deceleration; closely tied to the visual system that provides information to the vestibule located in the inner ear	Rocking in chairs or rocking body, riding on amusement park rides, dancing; twisting on bar stools, skating; sliding	Rocking body, spinning body, twirling in swings, head rocking

Each of us, even those of us with more intact central nervous systems, also tolerate differing degrees of stimulation. Look at the difference in the preferred musical tastes (and intensity levels) between the teenager and the forty-year-old. Although most teenagers enjoy megawatt rock concerts with all the trimmings, most adults are more inclined to seek out softer music or silence in a dimly lit room. In the same way, children with deafblindness need varying amounts and intensities of stimulation.

QUESTIONS TO ASK ABOUT SELF-STIMULATION

If we come to accept that self-stimulation is an important and valid activity for individuals without disabilities, then we must begin to revise our thinking about addressing self-stimulatory behaviors in individuals with deafblindness.

Can this behavior be stopped?

In looking for the answer to this question, first take a look at yourself. Try this little exercise. Identify one of your own deeply cherished self-stimulatory behaviors such as cracking your knuckles, humming, sliding a charm on your necklace, etc. Try to keep track of how many times during the course of a 24-hour period you engage in this behavior. Then spend the next 24 hours refraining from this behavior. If you succeed, then try to extinguish that particular behavior for a year. Stop this behavior under all kinds of circumstances: times of stress, times of idleness, etc. Once you have completed this exercise, answer the question for yourself. Your answer will either be a resounding “no” or a “maybe, if” depending on your particular success in completing the exercise.

Children with deafblindness (just like you and me) participate in self-stimulatory behavior to calm, to energize, to get feedback, etc. Most of the time you can’t completely extinguish the behavior, nor should you, because it does serve a purpose.

Can this behavior be redirected?

Most parents find that their child is more likely to participate in self-stimulatory behaviors when he/she is idle or stressed. Interacting with your child in some way may break up the self-stimulation. If the behavior appears in response to stress, finding ways to help him/her relax (e.g. massage, being wrapped up in a quilt, etc.) may reduce the amount of time spent in this behavior that you find inappropriate or harmful. If your child is left alone, however, it is likely he/she will re-engage in this activity as soon as the opportunity presents itself.

Can this behavior be “contained” by allowing it in certain locations or at certain times?

Some behaviors may present problems because they are considered socially inappropriate. Those of us who are smokers have learned to refrain from our favorite self-stimulation behavior on flights, but we all know exactly where to go in the airport to have that last cigarette before the flight leaves.

With some effort many children can learn to remove themselves to their bedroom or a private place when engaging in self-stimulation that is not considered socially acceptable. Using calendar symbols to represent this favored activity and scheduling the activity as part of the child’s day may help the child refrain from this particular self-stimulation behavior for increasingly longer periods of time and stay involved in other kinds of activities.

Can this behavior be modified or expanded into more “socially acceptable” self-stimulatory behaviors?

The value of a self-stimulatory behavior is what the behavior tells you about how your child takes in information. If your child likes to burrow down inside the cushions of the couch, be held or hugged a lot, or enjoys

massage, you can assume that he is motivated by information he receives proprioceptively. If your child likes to vocalize, listen to music, or bang things together next to his ear, you can assume he is motivated by information he receives auditorially.

These behaviors can be used as a way to explore the individual's preferred sensory channels for receiving information from the world. With this information we may find preferred sensory experiences around which we can develop more "mainstream" leisure activities for children that they will also come to view as "leisure". For example, if a child enjoys the visual sensation of lights we can find age-appropriate toys that might be motivating to him. In addition to familiar toys such as Lite-Brite, consider lava lamps, continuous wave machines, lighted drafting tables for drawing, and even some Nintendo-type games. You might also consider extracurricular events such as visiting arcades, decorating with lights for appropriate holidays, and/or lying in a hammock under a tree watching the play of light through the leaves.

Take time to observe the types of self-stimulation that your child participates in and when this behavior occurs. Watch him/her and make notes about what you see and when you see it. Then try to see if there is any pattern to these behaviors that will give you insight to the type or types of stimulation he/she prefers and the purpose it serves. At the same time note what types of activities he/she finds aversive.

When you have a good understanding about his/her preferences, begin to brainstorm ways that you can offer other stimulatory activities or perhaps modify or expand on the preferred self-stimulation. Ask for help from your child's teacher, physical therapist, occupational therapist, and others. Look at children of the same age and try to find toys or activities that may make the self-stimulatory behavior appear more "normal".

Sometimes your child's favorite self-stimulation activity can be modified or expanded in a way that will make it more socially acceptable. For example, everyone knows the "nail-biters", but do you recognize them when they become "the manicurists". Several of my friends substitute the more acceptable behavior of nail care for their favorite activity of nail biting. They carry a complete manicure set with them at all times and can often be seen in meetings quietly filing or clipping a nail. They buff, cream, and polish. They examine their nails for chipping, snags, splits. They are rewarded by others who admire their efforts instead of being held in low esteem as one of those nervous nail-biter types.

You should realize, however, that generally your child will need support from you to seek out these more acceptable behaviors. Their first preference will generally be for the behavior they have developed on their own.

Can the environment be engineered to make this behavior safer if the behavior is detrimental to the child or those around him/her?

People who like to jump off things are great examples of engineering the environment to make a dangerous self-stimulation behavior safer. These folks (skate-boarders, skydivers, skiers, etc.) have developed elaborate ways of placing themselves in extremely dangerous activities and surviving. We have industries based on protective clothing and equipment that will allow them to hurl themselves through space and make a safe landing.

Frequently, with children who put themselves in danger of bodily harm by participating in self-stimulation activities that are excessive to the point of creating physical danger to themselves or others, the best you can do is to provide protection. Splints, helmets and other devices sometimes must be used temporarily to protect the child and others around him/her.

Could there be physical or emotional factors provoking these behaviors?

In addition to providing protection from the effects of the behavior, it is important to look at the cause of the

behavior. Often times these behaviors erupt in response to real physical problems that the child is not capable of communicating to you. Emergence of these behaviors or increase in these behaviors, might indicate pain or decrease of sensation as in the case of retina detachment or ear infections. Seeking out appropriate medical examinations when this type of behavior emerges or escalates is very important to the health and safety of the child.

Emotional and environmental conditions may also provoke increases in these self-injurious behaviors. One individual I knew exhibited a dramatic increase in self-stimulatory behavior after the death of her father. The amount and intensity of the behavior posed concerns for her safety and the safety of others. Since there was no physiological basis for her behavior, the family spent a lot of time with her looking at pictures of her dad, going to the cemetery with her, and trying to participate with her in activities that were associated with her father. After a period of time, the behaviors decreased to levels that were in line with the period before her father's death.

Changes in schedules, changes in routines, or moves to new environments can also bring about increases in self-stimulation behavior. Helping the child to anticipate these changes and providing as much consistency as possible through routines during times of change, are strategies that may help to reduce the amount of this type of behavior.

CONCLUSION

Like you and me, children with deafblindness have a need to participate in self-stimulatory activities. Because their behaviors appear very different from our own and can interfere with learning or become dangerous, they are viewed negatively by many people. Changing our perception about these behaviors may help us deal with them in a better way.

There are a number of ways to deal with self-stimulatory behaviors. Plan ways to keep the child more involved with others during the course of the day. Work to help him/her contain the behavior, or engineer the environment to make the behavior safer. Schedule time into the day to allow your child time for this preferred activity. Look at ways to adapt the behavior so that it will appear more "normal". Learn to use the information these behaviors offer about your child's preferred channels of sensory input to develop recreational and social pursuits that may be enjoyable for him/her even if these activities will not entirely meet his/her "leisure" needs. Finally, accept that you will probably never completely extinguish the behavior without having it replaced by another self-stimulatory behavior. Self-stimulation is common to all humans and serves an important purpose.

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Preparing Your Daughter for Her Menstrual Cycle

By Robbie Blaha, Teacher Trainer

and Kate Moss, Family Support Specialist, TSBVI, Texas Deafblind Outreach

This article first appeared in the April 1992 edition of P.S. NEWS!!!

When a child begins to experience the physical and emotional changes that puberty brings, many parents feel unprepared to support their child through these changes. Helping their child learn to take care of her physical needs and, at the same time coping with behaviors that can occur, is a challenge. Parents of children with deaf-blindness do not escape this significant milestone in their child's life, and they too feel unprepared. Robbie Blaha, Teacher Trainer for Texas Deafblind Outreach at Texas School for the Blind and Visually Impaired, offers several suggestions for helping young women with deafblindness become more independent in menstruation management.

It is important to note that some of the suggestions may seem unnecessary for your daughter depending on her toileting skills and her understanding of social factors such as modesty and appropriate public behaviors. As you read the information that follows, consider your daughter's skill levels. You may want to make modifications in her instruction. If you are not sure how to modify these suggestions, you might want to contact a parent of an older child, your classroom teacher, or Robbie.

1. Provide instruction prior to your daughter's first period.

By starting in advance of the menses, parents and staff will have the opportunity to prepare the young woman in a positive manner. Let her become familiar with the pad by wearing one for specific lengths of time on a daily basis. This will allow her to learn about the pad without experiencing the added discomfort of being in her period for the first time. A young woman's period may bring some physical and emotional discomfort. Dealing with the unusual sensation of a pad may be unacceptable to her, and she may react by pulling off the pad repeatedly when it is first introduced. Should this happen, it will be less stressful for everyone if you are dealing with a dry pad in a private place.

Take time to let your daughter try out different pads and select the one that is most comfortable for her. Start with the smallest size available, such as panty liners, and build gradually to the thicker pads. It is better to change pads more frequently and use a thinner more comfortable variety than to engage in a power struggle with a young woman. Give your daughter time to practice the new skills involved in changing a pad (e.g. taking the paper strip off the back of the pad, attaching the pad to undergarments, disposing of the pad after it has been used, etc.). If you present these new skills only while your daughter is menstruating, she may not have enough opportunities in those few days each month to learn independence in the routine.

Educational staff teaching menstruation management should visit with the young woman's parents before beginning instruction. The parents have a lot of information about their child. They also have great concern about their daughter's progress and need to understand how instruction in this area will be carried out. Men-

struation is a very intimate subject; parents need to be reassured that their daughter will receive support and understanding as she goes through an experience that can be trying for any young woman.

2. Stay matter-of-fact when teaching menstruation management.

It is important to be positive, organized and relaxed. Address menstruation management as if you were teaching tooth brushing and hand washing. Be careful not to teach negative behaviors with this particular hygiene activity. If changing pads offends you or if you view training your child as a waste of time, your daughter may receive a negative message about the activity. Consider the situation of a caregiver hurriedly changing the sanitary napkin. The young woman reaches down to touch the pad. Her hand is pushed away abruptly several times. The caregiver's behavior upsets her, leading to a combative situation about the pad. Several exchanges of this nature across the day could set up a pattern of behavior that may be very difficult to change. Sometimes this can evolve into pulling at the pad, smearing menses, or other inappropriate behaviors. For young women who are already demonstrating noncompliant behaviors there is a risk for learning more serious behaviors.

While people in our culture may ignore someone who lays down on the floor at the mall, they probably will be less understanding, deeply offended or frightened by a young woman pulling off her sanitary napkin in a public place. Once learned, these kinds of behaviors are very difficult to redirect; so it is better to avoid their development in the first place. Even if inappropriate behaviors do not develop, treating a young woman abruptly while changing pads can make her feel that she has done something wrong. This is not fair to her and certainly not beneficial in developing a good self-concept about her body.

3. Help reduce your daughter's confusion.

Sometimes individuals confuse their period with a toileting accident and become distressed. They may keep insisting they need to use the restroom. If your daughter feels the need to go to the bathroom more often, let her. You can use this opportunity to practice changing the pad. Let your reassuring manner tell her that she is doing the right thing. Praise her success and be proud of her independence.

Another area of confusion is related to pad disposal. Your daughter may want to flush it down the commode like toilet paper. Take special care to guide her, hand-over-hand if necessary, to dispose of the pad in the proper container near the commode. You may want to consider purchasing a small trash receptacle with a lid that is used exclusively for this purpose. Schools may choose to purchase the type of wall containers that are found in most public restrooms to help make the environment as typical of other public restrooms as possible.

Parents should remember to practice these skills exclusively in the bathroom. If your daughter experiences pad changing in other places at home, she may assume it is appropriate to remove the pad in other places that may not be acceptable. Help her to understand that taking off her sanitary pad is appropriate behavior only in the privacy of the bathroom.

4. Handle menstrual problems in a proactive manner.

Before your daughter has her first period, make an appointment to talk with your family doctor or nurse about premenstrual stress syndrome. You should also discuss the need for a gynecological examination and start planning a way to assist your daughter in going through that examination. Don't assume this examination is not really necessary. Women with deafblindness are subject to the same health risks in this area as their peers who are nondisabled. It is also important to keep a record of her periods to detect irregularities that may warrant medical attention. Also, following a round of antibiotics, have your daughter checked for yeast infections which can cause discomfort, especially during her period.

Your doctor may suggest giving your daughter aspirin or a Tylenol-like product for the first several days of her period. This can help make her more comfortable, and may head off problems if her communication level prevents her from letting you know she has cramps. You may also want to change her daily routine, especially at school. For example, if she usually likes to jump on a trampoline, but keeps getting off during the first day of her period, give her other activity choices that are not physically taxing.

5. Don't expect the day to go as usual.

If your daughter or one of your students is in her period, just expect to get less done and know that your schedule may have to be adjusted. It is almost impossible to maintain the number of activities in a typical day and still find time to teach the critical skills of menstruation management. If you as a caregiver are too rushed, you will do most of the work yourself. When that happens an opportunity to gain independence has been lost.

It helps to actually schedule this hygiene activity into the day. For example, put a pad in a small makeup bag, place it in your child's room or student's calendar box, and have her be responsible for carrying it to and from the bathroom. If she uses a weekly or multi-weekly calendar, schedule her periods on the calendar. Help her to anticipate her period by going to buy pads at a grocery store. Talk about her upcoming period with her as you review the calendar together. If she does not use this type of calendar, use the bag with the pad as a topic of conversation during her usual hygiene activities. Make things easier for yourself by always having extra pads, latex gloves, and a change of clothing on hand. You can help her pack these items into a backpack for outings or trips to and from school. The better prepared she is for her period, the easier it will be on her and you.

6. When problems occur, try to see the activity from your daughter's perspective.

If she refuses to participate in the activity, consider whether this is a pattern of behavior she exhibits in other situations. Don't put any more emphasis on this activity than you would other types of hygiene activities. If you do, you may set yourself up for a power struggle.

You might understand the cause for her unwillingness to participate by noting other activities she does not like. Are their similarities between those activities and the menstruation management routine? For example, does she dislike touching tape or other adhesive surfaces? Does she have a preference for certain textures against her skin? Does she show some aversion to handling other things that are damp?

Consider the activity's design. Is she experiencing the same sequence of events every time she changes pads? Check with other caregivers that help her with this activity. If they are having the same problems you might help each other in finding solutions. If they are not having problems, you may want to adopt their approach.

7. Share knowledge of your child and the way you do things at home with the educational staff or other caregivers.

Probably the most important thing you can do to help your daughter become independent is to communicate with all of those individuals who will assist her in this activity throughout her day. If a particular type of pad is used because she finds it the most comfortable, be sure your teacher knows so it can also be used at school. If a medication for premenstrual discomfort is recommended by your physician, talk to the teacher and school nurse about the policy for administering the medication at school. Don't assume that a note from you will guarantee that the medication can be given in a school setting. If you know her period is about to start, send a note to the teacher so she is aware of behaviors that may result from this impending event. Work together to build strategies for supporting your daughter during this time. Most importantly, make sure school personnel are committed to making this experience a valuable learning opportunity for your daughter. Don't be shy about asking for their help. They may have experienced this many times before in their teaching career, while it may be your first time.

If you would like more information on this subject or would like to talk directly with Robbie about concerns you have in this area, please call or write to her at (512) 206-9232, Texas School for the Blind and Visually Impaired, Outreach Department, 1100 West 45th Street, Austin, Texas 78756; or send e-mail to her at blaha_r@tsb1.tsbvi.edu.

Another resource on this topic is: Fredericks, H.D. Bud, et. al., *The Teaching Research Curriculum for Handicapped Adolescents and Adults – Personal Hygiene*. 1980.

Suggestions for Recreation and Leisure Activities for Blind and Visually Impaired Children

By Debra Sewell, Teacher Trainer, TSBVI, VI Outreach

This article first appeared in the June 1994 edition of VISIONS

Although children play purely for pleasure and not for any goal-directed purpose, they acquire numerous skills during play. Creating fantasies, pretending, interacting with others, moving their bodies, and exploring their environment provide many opportunities to learn. It is important to keep in mind, however, that many children with visual impairments and/or multiple impairments will need to learn “how” to play with toys and games appropriately, as they don’t learn this by watching others.

Many games encourage children to develop basic cognitive concepts (recognition of letters, numbers, colors, shapes, and textures) while also promoting important social skills, such as taking turns, interacting with peers, and participating in group activities.

The following is a list of a few games and skill areas. These are readily available in toy stores and can be played by most blind children with no special adaptations.

1. Simon – auditory memory
2. Perfection – fine motor
3. Cootie – fine motor
4. Don’t Spill the Beans – fine motor
5. Hot Potato – social interaction

Musical/auditory toys are important for a visually impaired child as they offer auditory feedback and stimulation. There are many commercially available musical toys that are designed for a wide range of developmental levels. Chime toys, music boxes and musical instruments are good for developing fine motor skills and wrist rotation, and also learning about cause and effect.

1. Keyboards – finger strength and finger isolation
2. Wind instruments – lip closure and breath control
3. Instruments to tap (drums, sticks, blocks) – bimanual control
4. Instruments to shake – cause and effect
5. See ‘n Say – bilateral hand use
6. Spinning Tops – arm & hand strength
7. Jack-in-the-box – wrist rotation
8. Busy Poppin’ Pals – various hand skills

The selection of games is very important. The games should be aimed at the appropriate developmental level of your child, and adaptations should be made so they are suitable for a particular child, if necessary. Most importantly, the games should be playable with nondisabled peers.

In addition to using games that need no modifications, there are numerous adaptations that can be made to games that will allow blind and visually impaired children access to a wider range of recreation/leisure activities.

Some of these adaptations are:

1. Divide sections of game boards with glue, or various textures.
2. Add braille labels to sections of game boards.
3. Use velcro in sections of game boards and on bottoms of playing pieces.
4. Braille the instructions and the game cards
5. Tape record game instructions.
6. Braille regular playing cards or game cards such as Uno.
7. Use textures or glue to mark differences in game pieces.
8. Add brightly colored stickers to game pieces and game sections.
9. Mark dice with braille labels or glue dots.
10. Make a Tic-Tac-Toe board with a cake pan and magnet strips.
11. Divide checkerboard with glue and mark red playing pieces with texture.
12. Play Tic-Tac-Toe with pegs and pegboard.
13. Use a large box lid to define playing space.
14. Keep score with peg boards, paper clips clipped to index cards or tokens dropped into a container.

Most of these ideas are for adapting commercially available games. Adapted games such as Scrabble, Bingo, Tic-Tac-Toe, Checkers and large print and braille playing cards are also available through the following distributors:

1. American Foundation for the Blind
15 West 16th St.
New York, NY 10011
(800) 232-5463
2. American Printing House for the Blind
1839 Frankfort Ave.
Louisville, KY 40206
(502) 895-2405
3. Childcraft
20 Kilmer Rd.
Edison, NJ 08818-3081
(800) 631-6100
4. Howe Press
Perkins School for the Blind
175 North Beacon St.
Watertown, MA 02172
(617) 924-3409
5. JESANA Ltd.
P.O. Box 17
Irvington, NY 10533
(800) 443-4728

Here's Looking at You Mom: The Role of Gaze in Early Attachment

By Millie Smith, Teacher Trainer, TSBVI, VI Outreach

This article first appeared in the June 1995 edition of VISIONS

The first significant visual event in a baby's life is gazing at her caregiver's face. The baby is able to focus on objects about eight inches away. This is usually the distance between the caregiver's and baby's faces (Stern, 1977). By six weeks, the baby can look directly at her caregiver and hold the gaze with eyes widening. By three months the baby can follow the movements of her caregiver as she moves about at a distance (Morse, 1991).

The baby's relationship with her caregivers during the first three months of life is not limited to visual experience. Recently, hospitals have discovered that premature infants develop better if they are taken out of incubators for periods of time and held against the skin of the caregiver. The warmth provided this way fosters growth better than that provided by the incubator. Everyone knows the trick of quieting a new puppy by putting a clock in the basket to imitate the sound of a heartbeat. A baby also appreciates these sounds and the babbling and cooing caregivers are inclined to provide. The special significance of eye gaze in early attachment seems to be related to the fact that it is a shared communicative experience between the baby and caregiver. The message sent and received by both parties is usually, "You are wonderful."

There are three basic head positions of the baby that almost all adults interpret the same way. The head at midline with eyes looking straight at the caregiver is interpreted as an invitation for interaction. The caregiver tends to gaze back and coo when the baby's head is in this position. When the baby's head is turned slightly to the side, the caregiver usually thinks the baby is losing interest in her. She may do something to attract the baby's attention, or she may terminate the interaction. If the baby's head is turned sharply, lowered, or thrown back, the caregiver is likely to assume that the baby doesn't want to interact. The message received by the caregiver, sometimes unconsciously, is "Go away." or "Leave me alone." (Stern, 1977).

Caregivers of babies with visual impairments need to be aware that, for them, these head positions must be interpreted differently. Babies with visual impairments may turn their heads to the side because they see better straight ahead with their heads turned. Babies with little or no vision may turn their heads to the side, up, or down because they are listening and touching, not looking. Most caregivers will have to consciously override the strong instinct to interpret these head postures as requests to stop interacting. When a baby has a visual impairment, a better way of determining the right time to stop an interaction might be to read muscle tone, breathing rates, and vocalizations. For some caregivers, it will be a little harder to read invitations to initiate interactions. The direct straight-on head posture that signals readiness for interaction may never appear. Caregivers could wait for other signals like cooing or increases in movement, but some babies may take a while to learn those ways of communicating their desire for interaction. Perhaps the safest thing to do is to initiate interactions frequently without waiting for a request. So far, there is no evidence that babies suffer from too much attention in the first three months of their lives.

Caregivers can also do a couple of things to make it a little easier for babies with visual impairments to gaze at them. First, some parents have reported that they get much better eye contact with their babies when the baby is lying in its crib, rather than sitting up in its seat or being held. The baby can probably see the parent's face more clearly when it is lying down because the face has a clear background behind it - the ceiling. When the baby is more upright, the background behind the parent's face is more complex. The baby has a hard time figuring out what is face and what is furniture, pictures, wallpaper, etc. Second, the baby can put all its energy into gazing when its head is supported properly. If the baby is having to work to stabilize its head or other parts of its body, it has less energy left over for looking.

There is another factor that may influence gaze behavior in babies. Some babies with visual impairments have difficulty handling stimulation from multiple sources. They may compensate for this difficulty by responding to only part of a stimulus. Sometimes the part they respond to is not the part we expect them to find interesting (Morse, 1991). A baby having this difficulty might look at the hairline or an eyebrow rather than the eyes themselves. The caregiver may feel somewhat rejected. In fact, the baby may be trying to simplify its sensory experience. If the caregiver does what most caregivers do, she is gently swaying as she looks at the baby and coos at it. Not only that, she is probably changing her facial expression as she talks to the baby. This is a lot of stimulation. "As the complexity of these simultaneously presented sensory demands increase, the processing difficulties may correspondingly increase." (Morse, 1991) The baby is likely to fall back on her preferred sensory system at these times. If she has a visual impairment, that system is not likely to be the visual one and she may avert her gaze (Morse, 1991). In this case, the message is not "Leave me alone." It is "Give me a little less a little slower."

Caregivers can figure out ways to attach by using the unique visual style of the baby and/or by using other sensory input and types of communication when they realize that head posture needs to be interpreted differently for the baby with a visual impairment. With some adjustment, attachment can begin positively. The baby can learn that she has the power to draw her caregiver closer to her (Pogrud, Fazzi, & Lampert, 1992) and the caregiver can learn to pace her interactions according to the baby's processing needs. Mutual closeness between the baby and her caregivers is the launching pad for the development of skills related to everything else!

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An Introduction to Dr. Lilli Nielsen's Active Learning

By Stacy Shafer, Early Childhood Specialist, TSBVI, VI Outreach

This article first appeared in the June 1995 edition of VISIONS

Dr. Lilli Nielsen has worked as special education adviser at Refsnaesskolen, National Institute to Blind and Partially Sighted Children and Youth in Denmark since 1967. She was trained as a preschool teacher and psychologist. She has performed research in the area of spatial relations with infants who are congenitally blind and has written several books and articles about educating children with visual impairments and multiple disabilities. Dr. Nielsen's approach is called Active Learning. She has presented week-long training sessions on developing the full potential of young children with visual impairments and multiple disabilities in countries around the world. We were very fortunate that she presented in Dallas, Texas, May 1994. I was asked to write about some of the information she has shared with us.

All young children learn through play. They need to be encouraged to explore their environment and objects in their environment. Dr. Nielsen believes that all very young children learn by being active, rather than passive recipients of stimulation. We need to observe typical children to see how they learn to move their own bodies (raising their heads, reaching for objects, sitting up, etc.); use their bodies to explore their surroundings (including any and all objects within their surroundings); and actively participate in interactions with other people. A visual impairment prohibits a child from having enough opportunities to develop these abilities and have these experiences without intervention. She encourages adults to set up the child's environment so that s/he can do this.

Here are a few of Dr. Nielsen's recommendations when developing the child's environment:

- **Observe the child.** It is imperative that we know what the child can do, what activities s/he enjoys, what type of objects s/he likes, etc. Assessing the child's existing skills and preferences is the first step in programming. Observation will help you note the child's current developmental skills. A child's preferences are indicators of the underlying strengths of his system. These preferences can guide you in the selection of objects and activities. You need to know a child's repertoire so you can notice change and improvement.
- **Provide the child with more activities and objects that are similar to those he enjoys.** This will encourage the child to explore and experience new things and broaden his knowledge base. Young children with visual impairments need to be encouraged to explore, not only toys from the toy store, but also everyday objects around the house.
- **Give the child opportunities to practice and/or to compare.** As adults, we are often tempted to remove materials as soon as the child shows that s/he can use them. We all relate new information to things we already know. For example: The first time you successfully drove a car around the block, you still needed lots more experiences driving in different environments. For example, you needed to drive on different types of roads and highways, different vehicles, different times of the day and night, in different types of traffic, with the radio on and off, with friends in the car, and so forth, before you really mastered all the skills and concepts about driving. When a child begins to bang one object on another one, he needs to be

given the opportunity to bang lots of different objects on lots of different surfaces. (The sound produced when banging a metal spoon on the couch is much different than banging it on the coffee table or a metal mixing bowl.) Children need to be able to repeat an action many, many times in order to learn.

- **Provide a few materials and activities that are at a slightly higher developmental level.** This will provide a challenge for the child, so he doesn't become bored. You only model these activities for the child. You do not expect him to imitate.
- **Do not interrupt a child by talking when s/he is actively engaged in play.** Most of us have had the experience of talking to an infant who is busily kicking her legs and having the child stop kicking to listen to our voice. We need to refrain from talking to a child who is exploring or playing with an object or practicing a new movement. We should wait until the child turns to us to share her/his experience or at least until s/he takes a little break in the activity before commenting. This does not mean that we need to stop talking to our young children with visual impairments, just that we need to pick our moments.
- **Slow down when interacting with a child.** We must be willing to wait and give the child time to take a turn in the interaction. When playing with a child, Dr. Nielsen tells us to give the child time to explore an object alone, rather than jumping in and showing her/him how to use it. At a conference during a child demonstration, Dr. Nielsen offered a battery operated facial brush to a child. She let him explore the brush in his own way. He held the brush against various body parts, moved it from hand to hand, turned it over, put it on a tray, moved it against other objects on the tray, picked it back up, put it to his lips, and did many other things with it. Then he turned to Dr. Nielsen to share the experience. That was the moment she talked with him about the facial brush and the things he had done while playing with it.
- **Let the child have control of her/his own hands.** Dr. Nielsen feels that when we are interacting with a child who has a visual impairment, it is important not to take her/his hand and bring it to the materials. Instead, we need to develop alternate strategies for presenting objects to the child (e.g. gently touching the toy to the child's arm or leg to alert her/him of the object's presence, making noise with the object to arouse her/his curiosity and encourage her/him to reach out, placing several objects near or touching the child's body, so any movements s/he might make will bring her/his body in contact with an object, etc.).
- **Provide opportunities for the children to actively participate with their environment.** One of these "special environments" is the "Little Room". The "Little Room" consists of a metal frame supporting three side panels and a Plexiglas ceiling from which a variety of objects are suspended. These objects should be ones that the child finds interesting and enjoyable. This gives the child the opportunity to experience the properties of objects, to compare different objects, and to try out different things with the objects on her/his own without adults interpreting that experience for her/him. Since the objects are stable (secured to ceiling and walls), the child is able to repeat her/his actions with an object as many times as s/he needs to, at one to two second intervals, without dropping and losing them. The immediate repetition enables the child to store the information gained from the experiences in her/his memory.

Dr. Nielsen has given us lots of information about ways to encourage a child with a visual impairment to learn and develop. For more information about Dr. Nielsen's Active Learning, contact the Consultant for the Visually Impaired at your Education Service Center or call Outreach Services at Texas School for the Blind and Visually Impaired.

REFERENCES:

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O&M for Preschool Children: A Developmental Approach

Adapted from a presentation by Susan S. Simmons, Ph.D.

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A number of years ago I began referring to myself as a "Developmental O&M Specialist". I choose this term because many O&M Specialists seem to come from one of two schools of thought when providing services for young children. Since most of us were trained from the adult model, if the person does not have a background in child development the tendency is to take adult skills and try to simplify them for children.

I was a child development specialist who became an O&M. When I went through my training I couldn't help but think of ways to implement some of the techniques in a very different manner with young children. Because of this difference in background, I think in terms of child development instead of O&M development.

In the past ten years or so many people have published articles, curricula, assessment tools, as well as ideas on how to effectively work with young children who are visually impaired. I have had the wonderful opportunity to speak at numerous conferences on this topic, and I have found that discussing O&M in the context of a child's development is very well received.

It is vital that we think about O&M differently when teaching young children as opposed to adults. We need to realize that everything we do with children under five years of age is related to their understanding of space or their ability to move through space. For that matter, sighted children at this age also focus on learning about where they are in space and how to make their body move through space.

The most important factor in developing a successful O&M program for preschool children is the philosophy that independence permeates everything you do.

SO, WHAT IS O&M FOR PRESCHOOL CHILDREN?

Here are a few areas not usually associated with traditional O&M:

1. O&M is our attitudes, and the attitudes of all who come in contact with this child.
2. O&M is our commitment to that child's independence at whatever level she is capable.
3. O&M is the language we all use with our children and how, even subconsciously, we encourage independence.
4. O&M is valuing the child's skills. Our values often clearly indicate that anything short of being able to see the environment is a disappointment.

A FEW WORDS ABOUT CANES

It is absolutely normal for all young children to want to do things for themselves. We often brag about all the things that the sighted child can do independently. It is critical to develop the same expectations and opportunities for the child who is visually impaired. The child's self-image and the attitudes of those who work with her will be greatly influenced by the O&M Specialist's attitudes and expectations, especially as they relate to the use of canes.

I get very excited about teaching cane skills. A cane can be one of the simplest tools a child uses for independent travel skills. As the child develops, so will her cane skills. As she begins to have more body control, she will exhibit more cane control, and more complex techniques can then be introduced. These decisions are made based upon the child's environmental needs as well as her emotional readiness.

In my experience, families are either very interested in their child learning to use a cane or highly resistant to the introduction of the cane. It is very important for professionals to tune into the concerns of the family. Many families may feel that a cane will bring too much attention to their child. They may find it embarrassing if people stare, watch their child, or stop and ask questions. Some parents feel that if they hold the child's hand and lead them around, other people will not notice that the child is blind or visually impaired. Although these feelings are an understandable part of the acceptance process, it is vital to work through them with the family.

SUGGESTIONS FOR ENCOURAGING INDEPENDENCE IN THE HOME AND CLASSROOM

- Mark children's chairs and "cubbies" with an indicator, such as a shape. Then a child will not only be able to distinguish her own chair or cubby, but can also identify other children's. This technique also helps children learn about sequencing.
- Encourage independence, but make adaptations for safety. For example, a rug placed near a step or doorway can cue the child to slow down. For children with functional vision, you can use rugs with color contrasts to alert them visually.
- Keep toys in categories and in specific places so children can go and get them without your assistance. For example, keep all of the musical instruments in the big basket by the window, or keep the carpet squares for music on the bookshelf. This offers children the opportunity to go and get things they want for themselves.
- Don't be afraid to rearrange the classroom or home environment. Obviously you don't want to be rearranging the environments on a monthly basis. It is not a bad idea, however, to do it a couple of times per year (depending upon the abilities of the children in your class). Reorient the children to the new arrangement, and make it an exciting experience to explore and look for favorite items. This reduces rigidity, and offers children the opportunity to learn a new arrangement in a familiar setting.
- Avoid carrying kids as much as possible. They need to experience rolling, crawling, walking, trailing, and changes in textures. Whenever possible, let them travel to places on their own.
- Use natural sounds available within the environment when establishing auditory cues. It is really easy to fall into the habit of tapping on walls and furniture. Instead, if the child is walking or crawling to the bathroom, turn the water on and off in the sink. Entice her to listen. (Turning a sound on and off makes it easier to localize.)
- Pay attention to your orientation when you want a child to follow your voice. If they are following a

wall, you follow the wall and face the child. (It can be really helpful to be down at the child's level, which makes your voice very easy to localize.)

- Encourage a child to trail or walk using sighted guide everywhere she goes! The more she practices these techniques in familiar environments, the more likely she'll be able to use them in unfamiliar environments. For example, to help her get into the habit of trailing in familiar environments, as you enter buildings ask, "Where's the wall?"
- Talk about sequences of rooms, toys, etc. whenever possible. This will help the child learn to think sequentially (i.e., what comes next).
- Make a habit of pointing out environmental changes, or ask the child to tell you about environmental changes. For example, the tile floor changes to carpet, sounds change, etc. These skills help build environmental awareness.
- Encourage the child to use riding toys.
- Give the child opportunities to climb on various structures and explore new environments.
- Vary environments as much as possible; sandboxes, grass, trees, mud puddles, ice, snow, rain, etc. (Looking for worms after a rain is a big thrill for very young children!)
- Help children be "detectives" as they investigate and identify sensory information. Instead of telling them what is in their lunch box, tell them, "Smell the sandwich," "Touch the fruit," etc. At snack time offer two or three kinds of juices, and ask what kind of juice is in the glass? The children can first smell, then taste their juice to identify it.
- Use spatial and directional concepts as much as possible. For example, right and left can be used in conjunction with "side" as in "The door will be on the right side of the wall." or "The door will be on my side to the left." When giving directions, use terms such as "in front of", "behind", "above", "below", and "next to" with children who can learn these concepts.
- Make all activities functional. Walking to the front of the building may be meaningless to a young child, but going to the water fountain may be very interesting.
- Try to incorporate a sense of adventure and excitement about everyday discoveries.
- Help your students practice auditory discrimination skills in naturally occurring situations. For example, someone entering a classroom may say, "This is Susan." It is more natural for the classroom teacher to greet the person ("Hi Susan!") or, once she speaks, to ask one of the children to name the visitor. Many kids are very good at identifying familiar people but do not have enough opportunities to practice the skill with people they don't know as well.
- Use visual landmarks that have high color contrasts with children who have low vision.
- Arrange furniture to limit the amount of open space. It is easier to navigate a room if landmarks, such as furniture, help break up the space. It is more difficult to remain oriented in a room with large amounts of open space. Put furniture in useful and reasonable places. Just keep in mind, the less open space the better.

Check Out Family Village

By Kate Moss, Family Support Specialist, Texas Deafblind Outreach

Frequently, I need to get information about a specific condition or syndrome for myself or for a family I am working with, or I want to find some resource about disability issues. One of my favorite resources has become Family Village, a website sponsored in part by The Joseph P. Kennedy Jr. Foundation and The Mitsubishi Electric America Foundation that brings together a wide range of information for families and individuals with disabilities.

When you first arrive at Family Village, by opening the location <www.familyvillage.wisc.edu/>, you will see twelve icons or pictures that represent the website's different sections. The sections at this site and what is found in each, are describe in the table below:

Section	What You Can Find There
Library	Information is available about specific syndromes and conditions with links to other websites and resources. General information includes topics on general disability issues such as Adults with Disabilities, Advocacy & Public Policy, Air Travel Rights and Regulations for People with Disabilities, Auditory Integration Therapy, Conferences, Ketogenic Diet Resources, Siblings of Persons with Disabilities, Ventilator Use, and much, much more.
Coffee Shop	Here you can learn how to make connections with other individuals or families. Information is also available about several avenues you can explore to make these connections: chat rooms, Internet relay channels, and traditional parent to parent matching programs.
Hospital	Information is included about medical, health, transportation, therapeutic, and supportive resources. Topics include, among others, Alternative/Complementary Health Links, Charitable Transportation Resources, Cooking and Nutrition, Dental Information, Health Care Advocacy and Financing, Managed Care, Pharmacology & Drug Information, and Supports for Seriously Ill Children and Their Families.
Shopping Mall	This Mall lists resources for adaptive products and assistive technology. Topics include Adaptive Clothing & Shoes, Adaptive Daily Living Products, Adaptive Driving/Riding Products & Vehicles, Adaptive Switches, Adaptive Toys, Canes and Walkers, Communication Aids (sensory disabilities included), Equipment Loan or Exchange Resources, Funding for Assistive Technology, Incontinence, Seating and Positioning Products, and Wheelchairs and Equipment, etc.
House of Worship	This section includes religious/faith/spiritual resources for those who have disabilities.
Post Office	If you are a parent of a child with a disability or an adult with a disability and would like to talk with someone else who has "been there", you can post a message.

SYNDROMES/CONDITIONS

Section	What You Can Find There
School	This School includes educationally-related resources for families with a child who has disabilities, plus additional resources "JUST FOR KIDS!!" In this section you will find information on such topics as Advocacy and Public Policy, "Disability Awareness" Educational Resources, Early Intervention Resources, Government Agencies, IDEA and Other Education Related Laws, Inclusive/Special Education Resources, Individual Education Plan Resources, Parent Training and Information Centers, and Transition.
Recreation and Leisure	Topics in this section include Art, Music, and Theatre, Camps, Comprehensive Sports Resources and Programs, Cycling and Mobility Resources, Dance, Fitness and Exercise, Gardening, Golf, Horseback Riding and Hippotherapy, Hunting, Internet Discussion Groups, Radio and Television, Sailing, Sled(ge) Hockey and Picking, Snow Skiing, Special Sporting Events, Special Olympics, Travel, Water Sports (fishing included), and Wheelchair Sports.
Community Center	This Center includes resources for persons with disabilities, their families, and those that provide them services and support. Topics in this section include: Adoption Resources, African American Resources, Father Resources, Foster Care Resources, Grandparent Resources, Military Family Resources, Native American Resources, Public Transportation, Regional Resources in Other Countries, the United States and in U.S. Territories, Single Parent Resources, and Wish Granting Organizations.
Bookstore	The Bookstore includes reading, audio, video, and musical resources related to disabilities.
Information	This section contains the Family Village Search Engine and other information such as a terrific Guide to Using the Internet For Parents of Children with Disabilities or Chronic Health Conditions and Internet Relay Chat.
University	The University section includes links to disability research programs and projects, statistics and surveys.

This website is very easy to use, even if you have never spent much time on the Internet. The design is one that I find to be very user-friendly. People using screenreader software will find it very accessible. Family Village is always a good first place to go if you are not sure how to locate a resource or information related to disability. The other thing I like about this site is the inclusion of electronic bulletin boards, a good search engine, and abundant links to other great websites.

If you are just beginning to use the Internet, your first stop should be the "Information" section for a quick read-through of the "Guide to Using the Internet for Parents of Children with Disabilities or Chronic Health Conditions." You'll feel like a pro in no time. If you do not have Internet access at home, you may find this reason enough to take a trip to the public library to access the Internet there. You might also contact your school about making computers accessible to parents. If you would like to contact the folks at Family Village, you may write to them at: The Family Village, Waisman Center, University of Wisconsin - Madison, 1500 Highland Avenue, Madison, WI 53705-2280; or e-mail: familyvillage@waisman.wisc.edu.

Prevent Blindness Texas

By Diane Ingram, Executive Director
Texas Society to Prevent Blindness, Austin Branch

The National Society to Prevent Blindness was founded in 1908 out of concern for babies born blind due to their contracting gonorrhea from their mothers. Since the blindness caused by this disease can be cured by the simple application of eye drops at the time of birth, the Society's first challenge and success was to force the mandatory utilization of drops for all infants at birth. But that was just the beginning. The Society became dedicated to fighting blindness and saving sight for all persons.

The national office is located in Schaumburg, Illinois, with field operations in California, Indiana, Connecticut, Iowa, Florida, Massachusetts, Georgia, Nebraska, New Jersey, Tennessee, North Carolina, Texas, Ohio, Utah, Virginia, Oklahoma, Wisconsin, New York, Arizona, and Kentucky.

In 1956 the Society was established as a nonprofit, voluntary health agency in Texas and was incorporated in 1965. In the late 1960s Dr. Otto Lippman and a small group of dedicated professionals brought the programs of the Society to Austin. They primarily performed vision screenings in the schools and tried to make parents and teachers aware of some eye problems encountered by children that might affect the way they studied and performed in school. It was not, however, until the early 1970s that the Austin branch was officially organized. At that time it was known as the Texas Society to Prevent Blindness. In February 1994, the name was changed to Prevent Blindness Texas.

There are ten branches of Prevent Blindness Texas, with the state office located in Houston. All branches, with a few exceptions, support the programs described below.

The Austin Branch serves twenty central Texas counties (Menard, Kimble, Mason, Gillespie, Llano, Burnet, Blanco, Hays, Caldwell, Travis, Williamson, Bell, Milam, Lee, Bastrop, Fayette, San Saba, McCulloch, Lampasas, Coryell). The programs currently in effect in the Austin area are: Children and Adult Vision Screening, Partners in Prevention Program, Play It Safe Program for School Age Children, Safety in the Home and Workplace, and the Age-Related Macular Degeneration Support Group.

CHILDREN AND ADULT VISION SCREENING

The Children Screening Program screens children for visual acuity, strabismus and amblyopia. The Adult Screening Program screens for glaucoma. We perform these screenings at day care centers, private schools and health fairs.

PARTNERS IN PREVENTION PROGRAM

The Partners in Prevention Program provides free eye exams for homeless and indigent adults. To qualify for this program an individual may earn no more than 150% of poverty level. The exams are donated by ophthalmologists and optometrists in the Austin Branch area. If a client needs glasses after the exam, we contact optical stores in the area to see if we can get glasses donated.

VSP PROGRAM

We have a similar program for children 18 years and younger. It is called the VSP Program whereby children can receive both an eye exam and glasses from a vision specialist in the area. The criteria for this program requires that the child or parent must have a social security number and have an income no more than 200% of poverty level.

PLAY IT SAFE PROGRAM

The Play It Safe Program is an educational kit aimed at children from pre-kinder through third grade. This package includes a video, coloring book and curriculum booklet for teachers. A puppet show that teaches young children about eye health and safety is performed in conjunction with this presentation.

SAFETY IN THE HOME AND WORKPLACE PROGRAM

The Safety in the Home and Workplace Program involves presentations and informational material covering all aspects of eye safety and first aid. We make presentations on battery safety, hazards in the workplace, safety in and around the home, and sports safety.

AGE-RELATED MACULAR DEGENERATION SUPPORT GROUP

Our Age-Related Macular Degeneration Support Group meets quarterly at different locations throughout the city. We invite different speakers to these meetings to present on topics pertinent to this disease, such as nutrition, low-vision aids, and surgical breakthroughs that would interest persons with AMD.

The Prevent Blindness Office has educational material on most forms of eye injuries and diseases, available upon request.

All of the above services are offered at no charge to the public. Donations, however, are always welcome. For more information, the State Office can be reached at (888) 98-SIGHT. For local information the Austin Branch can be reached at (512) 459-8936. You are also welcome to visit the Prevent Blindness America website at <www.prevent-blindness.org>.

The ABCs of CSPD for TCB

By Scott Bowman, Director of Human Resources
Texas Commission for the Blind

The Texas Commission for the Blind, along with other vocational rehabilitation agencies around the country, is responding to federal requirements referred to as CSPD (Comprehensive System of Personnel Development). When the 1992 Rehabilitation Act amendments were passed, we were introduced to a new Section 101(a)(7), which is the CSPD initiative. The intent of Congress in this legislation - which was reinforced with the 1998 amendments last summer - was to ensure that consumers are receiving services from qualified rehabilitation professionals. The current effort is focused on vocational rehabilitation counselors, which, in TCB, extends to transition counselors.

The federal regulations have required state agencies to establish personnel standards that are “consistent with any national- or state-approved or recognized certification, licensing, or registration requirements.” In Texas, we have not required certification or licensing for applicants or employees, so we began looking at the national standards. The Commission on Rehabilitation Counselor Certification is the entity which issues the Certified Rehabilitation Counselor (CRC) certification to rehabilitation counselors who demonstrate a certain level of proficiency by passing a rigorous exam after achieving certain educational and employment (work experience) requirements. To be eligible to sit for the CRC exam, one needs to have a master’s degree in rehabilitation counseling or a master’s degree in a related field combined with specific work experience and supervised practicum experience.

So what does all this mean for counselors at TCB, and what impact will this initiative have on services to

blind and visually impaired Texans? At TCB, we have redesigned job vacancy notices, starting in April 1999, to allow applicants with a master's degree in rehabilitation counseling (and the necessary supervised practicum hours) to be considered for a counselor position with no paid work experience. In situations where it is not possible to recruit such individuals, applicants with other related degrees, combined with paid work experience, may be considered for openings. Individuals who are hired without the master's degree in rehabilitation counseling must agree to meet the CRC eligibility requirements within five years of their date of employment.

For current vocational rehabilitation counselors and transition counselors, the agency is allowing a five year period, starting in September 1999, for those staff members to acquire the necessary educational and experience requirements necessary to sit for the CRC exam. Although it is anticipated that some staff will choose to take the exam, TCB is not requiring CRC certification as part of the CSPD initiative. Employees will be expected to meet a two year "payback" requirement following completion of their master's program in instances where the agency or the university provides financial assistance for tuition or fees. This payback is an agreement that the employee will pay back the taxpayers by agreeing to work for TCB for this two year period, or reimburse any expenses paid on their behalf. The payback period, of course, is no guarantee of employment since TCB and most other Texas employers operate in an employment-at-will environment.

You're probably thinking to yourself, "There must be some type of grandfather provision, whereby a counselor with demonstrated success on the job could save the taxpayers some money and be exempt from all of this!" Our federal partner has been very clear on their position that, since this notion to increase qualifications in the profession originated from consumer input around the nation, there will be no exceptions to the general requirements. Individual agencies must develop plans to systematically develop their workforce to a point where counselors are considered "qualified". At TCB, as in many other agencies, we are very sensitive to the fact that counselors may have family obligations, geographical considerations, second jobs, or other legitimate barriers which affect one's ability to return to school. As one counselor recently commented to me, "I want to continue doing my job - working with consumers and employers - but I just don't have the energy or interest in returning to school at this point in my career."

Other counselors are excited about the possibility of increasing their professional credentials with significant financial support from the agency. TCB has not funded participation in degree programs before, so this is a real opportunity for staff who otherwise would not be able to complete a master's degree in their field. In the not too distant future, people interested in vocational rehabilitation counselor positions - whether in private rehabilitation or in the public program - will probably have to be certified (CRC) and/or have the necessary master's degree in rehabilitation counseling or a closely related field. In the short run, though, the challenge is matching interested staff with the limited slots available in the accredited educational programs in Texas and around the country. In many instances, agency staff will be experiencing "distance learning" courses in order to balance school requirements with the demands of a full-time job.

If you've followed along so far, you are probably ready for the answer to the other question, which was the projected impact on our consumers. TCB's administration has made it clear to counselors and supervisors that the current focus on providing quality vocational rehabilitation services to the blind and visually impaired people of Texas will not be diminished by this initiative. The agency's consumer satisfaction surveys are at an all-time high, which means that consumers are generally very happy with the services they receive from the agency. Can we improve? Of course we can. Will the CSPD initiative improve services? Only time will tell, but the hope is that counselors will gain more than a sheet of paper to hang on the wall. The universities, especially in our federal Region VI, are aggressively working with us to make their courses accessible, practical, and affordable to our staff. We're optimistic that this CSPD initiative will help us improve the credentials of our workforce and ultimately will improve the quality of services to Texans who are blind or visually impaired.

Providing the BEST Program for the Eyes of Texas

By Ron Lucey, Consumer Resources Coordinator, Texas Commission for the Blind

BEST is the acronym for the Blindness Education, Screening, and Treatment program. The legislature enacted this voluntary program in 1997. The BEST program is jointly administered by the Texas Department of Public Safety (TDPS) and the Texas Commission for the Blind (TCB). BEST is a way to educate Texans about the preventable causes of blindness, provide vision screenings to identify individuals with conditions that may cause blindness, and provide vision-related medical treatment for Texans with inadequate medical coverage.

Texans have the opportunity to make a voluntary contribution of one dollar to fund the BEST program each time they renew their drivers license or state ID card. This year, the 76th legislature approved TCB access to funds collected since the BEST program was enacted by the previous legislature. TCB has allocated the entire FY 1999 program budget to the development of a mass-media public education campaign to prevent blindness. The Commission will select an advertising vendor through a competitive bid process to develop and implement the public education campaign. This vendor will also develop and produce publications, public service announcements for radio and television, and other materials to promote the prevention of blindness. BEST education is targeted to a statewide universal audience. TCB anticipates the implementation of the public education campaign during the fall of 1999.

The TCB Board will meet in August to consider the establishment of rules to address BEST eligibility criteria for screening and treatment. Following the adoption of board rules, TCB anticipates the implementation of the BEST vision screening component beginning in the fall of 1999. The treatment component will be implemented later following the establishment of a treatment budget. The BEST treatment resources focus on individuals who have inadequate health insurance coverage and are at a high risk for vision loss.

The Workforce Investment Act (WIA)

By Ron Lucey, Consumer Resources Coordinator, Texas Commission for the Blind

Public Law 105-220, the Workforce Investment Act (WIA), was signed into law by President Clinton on August 7, 1998. The WIA is the single greatest overhaul of the nation's workforce system since the original passage of the Wagner-Peyser Act more than 55 years ago. This broad-reaching law coordinates many federal and state employment programs under a single delivery system. The wide array of employment, job search, and training services is delivered locally through the one-stop workforce center. In Texas there are presently 102 local one-stop workforce centers. Each full service one-stop center offers universal employment services to the general population including individuals with disabilities.

One of the most significant changes under WIA is the provision for local control of the workforce system by an employer driven Workforce Development Board (WDB). The chief elected local official, either the mayor or county judge, appoints the board members for each workforce board. More than half of the Workforce Development Board must include representation by local employers. Other WIA required partners represented on the board include local education agencies, labor, higher education and vocational rehabilitation.

The Texas Workforce Commission (TWC) is the state agency responsible for statewide WIA implementation. WIA statewide planning activities are the responsibility of the Texas Council on Workforce and Economic Competitiveness (TCWEC). The state Council members are appointed by the governor and mirror the representation of the local workforce development boards. However, a grandfather provision of WIA allows

states who choose early implementation of WIA to retain their existing state and local workforce board structures. Texas has chosen to become an early implementation state; therefore, vocational rehabilitation is not represented on the Council.

WIA includes the Reauthorization of the Rehabilitation Act in Title IV, which is implemented by the Rehabilitation Services Administration. Under WIA, the vocational rehabilitation system remains a distinct and separate program more closely coordinated with the workforce system. The workforce provisions contained in Titles I, III and V are implemented by the U.S. Department of Labor. Title V is implemented in partnership with the U.S. Department of Education.

The Workforce Investment Act titles include:

- Title 1 Workforce Investment Systems
- Title 2 Adult Education and Literacy
- Title 3 Workforce Investment-Related Activities
- Title 4 Rehabilitation Act Amendments of 1998
- Title 5 General Provisions

The WIA seeks to change the status quo of the nation’s workforce system through seven key principles:

1. Streamlining of services through the integration of multiple employment and training programs delivered by the one-stop service centers;
2. Empowerment of individuals with the information and resources they need to manage their own careers through Individual Training Accounts and better information on service providers and the skills demanded by employers;
3. Universal access to a core set of career decision-making and job search tools for all job seekers;
4. Increased accountability of the delivery system to achieve improved results in job placement, earnings, retention in unsubsidized employment, skill gains, and occupational/academic credentials earned;
5. A stronger role for local boards and the private sector emphasizing strategic planning and oversight of the one-stop delivery system;
6. State and local flexibility to ensure that delivery systems are responsive to the needs of local employers and individual communities;
7. Improved youth programs that strengthen linkages between academic and occupational learning and other youth development activities.

WIA authorizes several youth activities that include many of the same services provided by TCB’s Transition program. Youth activities include enrichment programs, education and employment related activities, mentoring, training, continued supportive services, recognition and achievement incentives, and opportunities for activities related to leadership, development, decision making, citizenship and community service.

Local youth councils are appointed by each Workforce Development Board to plan youth employment opportunities. WIA requires the state plan to describe the State’s strategy for providing comprehensive services to eligible youth, especially those having significant barriers to employment.

The employment provisions of WIA require the promotion and development of employment opportunities, job counseling, and placement of people with disabilities. The Texas Workforce Commission must describe how the state will serve the employment and training needs of individuals with disabilities. WIA also requires the state plan to include provisions for cooperation between the state’s vocational rehabilitation agencies and employment services. The plan must describe procedures to be taken by the state to assure coordination and avoidance of duplication between the employment service and vocational rehabilitation.

The Texas Commission for the Blind is working with WIA partners at the state and local level to coordinate the delivery of employment services to blind and visually impaired job seekers. The development of memorandums of understanding at the state and local level will designate responsibility for service delivery and clarify each partner's role in the workforce system. The expected result of this process will be an improved and more accessible workforce system. The success of WIA and its key principles will be measured in part by how well it serves those individuals requiring more intensive employment services and accommodations including persons with disabilities.

Choosing to Carry a Full Golf Bag: An Informed Choice

By Terrell I. Murphy, Executive Director, Texas Commission for the Blind

I received an e-mail recently that grabbed my attention. It read: "Golf teaches that even though you may not always win, you do have a good shot at being the best you can be." I don't know who the author was, but the person would make a good rehabilitation professional. Whether a blind child strives to be a nuclear physicist or an adult with a vision impairment wants to work in supported employment, our job is to improve their shot at being the best they can be.

A person's chances of becoming a golf pro are pretty slim without golf lessons. Learning to play with only one wood and a putter reduce those chances even more. I'm not a golfer, but I know that a seven-iron will get you closer to the hole from 100 yards out than a putter. A golfer needs all the tools of the trade to achieve the maximum results --- instruction, practice, and experience with a range of woods and irons.

In rehabilitation, as in golf, the chances of a blind or visually impaired person achieving his or her best are greater with instruction, practice, experience, and a full set of skills from which to choose to travel, read, write, communicate and take care of personal needs. Choosing the right iron for the distance in golf equates to choosing the right skill to do a particular job in rehabilitation terms.

Each year TCB serves as coach and instructor to thousands of people with severe visual losses who are in the process of choosing the skills that will allow them to be the best they can be. One of the challenges most people must overcome in this process is tackling lessons that may seem unneeded or hard at the time. A good example is learning braille. Braille is an invaluable reading and writing tool for people without vision as well as people with limited vision. Even a person whose vision is stable lives in an unstable environment. There will be times when large print is not available, the lighting is dismal, or the CCTV won't fit in the suitcase. Braille is not the answer in all situations, but it is definitely an efficient option in others. Similarly, many adults without usable vision may not realize the value of being able to read braille because their current system of using taped information seems to be working well enough. Adding the option of braille to the person's golf bag provides another choice when the tape player starts eating tapes for lunch.

Having a wide range of skills *maximizes* any person's opportunity to succeed at whatever he or she wants to do. TCB's job is to share what we know in such a manner that the person makes wise choices from an informed perspective. I love what my respected colleague, Phil Hatlen, said so eloquently in the last issue of SEE/HEAR: "What education and rehabilitation should be doing is developing independent choice-makers, proud and productive people who know themselves well and will not let anyone else take charge of their lives." I agree completely with Phil. TCB is committed to providing services that result in Texans who are confident and in charge of their lives. My challenge to you as people with choices is to fill your bags with every skill you will need to be the best you can be.

Of Pride, Determination, and Self-Esteem

By Phil Hatlen, Superintendent, Texas School for the Blind and Visually Impaired

On April 30 and May 1, the Texas School for the Blind and Visually Impaired (TSBVI) hosted the annual track meet of the South Central Association of Schools for the Blind (SCASB). Track and field athletes and other performers descended on TSBVI from the schools for the blind in New Mexico, Mississippi, Louisiana, and Alabama. In all, over 120 athletes, their coaches, and others came to Austin for this event.

I'll briefly tell you about important events that happened over the two days, then describe my reaction to the track meet. Coaches from all the teams met to plan future events. Superintendents from the schools met to discuss rules, funding, and other topics. On Friday night, representatives from all the schools participated in a music and talent program that delighted and entertained a large audience. When SCASB resumed competition between the schools about three years ago, it was decided to have opportunities for students to perform in nonathletic events for one another. This would allow more students to participate in these inter-school events.

There were many opportunities for the students to mingle and become acquainted with their peers from other states. Some renewed friendships that had blossomed during previous meets. Others made new friends. They ate their meals together, had leisure time together, and had a wonderful dance on Saturday night, sponsored by the local Delta Gamma fraternity. For blind and visually impaired students, the chances to broaden experiences and meet new people from other parts of the country can be rare. So, these two days meant far more to the participants than the track events.

However, most profound for me was the track and field competition. TSBVI has both wrestling and track teams that have a number of meets every year. In track, it is always with other schools for the blind. In wrestling, TSBVI sometimes competes with local schools. In my years at TSBVI, I have seldom had the opportunity to attend these events, for a variety of reasons. But, I decided that I would not miss the SCASB track meet. So, beginning on Friday afternoon and through most of the day on Saturday, I sat and watched some of the most amazing athletes I have ever seen.

No, they were not exceptionally fast, nor was their endurance amazing. They did not jump particularly high or far. And, yes, they came in all sizes and shapes. The scene did not necessarily resemble a NCAA Division - I meet. But the commitment and determination of the athletes made all of the above insignificant. Never have I seen athletes try harder! Never have I seen more "grit" and competitive spirit! Never have I seen more humble winners and more proud losers. Every athlete competed with pride. Sure, they cared about their standing against other athletes. But they were so proud just to be competing that the spirit of the athletes produced the most wonderful atmosphere.

I saw athletes foot-fault on the broad jump, then come back with even more determination. I saw runners fall, hurt themselves, get up limping, and finish the race. I saw them stumble across the finish line, never having given a thought to quitting. I saw runners lapped by the winner, but with clenched teeth and sheer determination, finish the race. I saw officials who would never consider ending a race until the last runner had crossed the finish line, no matter how long it took. But it was the fierce competitiveness and the personal determination that completely awed me. It was the true spirit of fair play, of cheering on one's opponent, of wanting all one's fellow athletes to succeed that permeated the events.

I doubt that what I've said captures the mood and aura of the event and does it real justice. If it does, I urge you to consider what moments like this mean to young people. My one additional overriding thought, as I watched these young men and women perform, was this: If these students had been attending an inclusive program in a local high school, probably none of them would have had this experience. Whether a regular high

school would have allowed these young people to compete is problematic. There is simply too much emphasis given to winning in high school athletics today. No, the runners and jumpers and shot-putters I saw would not make the team in their local school. And think of what they would have missed!

But, you may ask, don't events like this, similar to the Special Olympics, give students a distorted view of their ability? Perhaps, but is that important? Do blind children always have to be compared to sighted children? Isn't it good and healthy to have blind and visually impaired children test their skills against other blind and visually impaired children? As Omar felt that ribbon break across his chest at the finish of the 1000 meter run, do you really think he cared whether the athletes behind him were blind or sighted?

Self-esteem is an elusive and fickle feeling. It comes and goes in all of us. Its presence makes us feel really good and warm all over. We get it when we realize that we are good at something. We are good at reading; we are good at math; we are good in orientation and mobility; we are good on the Braille 'n Speak; we are good at running or jumping. Our feet feel lighter, we walk a little taller, and, best of all, a small voice inside us says, "Phil, you really did that well." That's self-esteem, and we all need it from time to time, or life is the pits. If you have never read what Sally Mangold has to say about self-esteem, and what it does to children, I urge you to do so.

Oh - one last comment on the track meet. A consultant in visual impairment from one of the Education Service Centers in Texas attended the entire event, as she gets ready to sponsor a similar event in her region for blind and visually impaired students who attend local schools. You know what? You'll see the same pride, determination, and self-esteem in the athletes at her event that I saw a few weeks ago. These kinds of experiences for students should not be confined to schools for the blind.

Texas Healthy Kids

By Carlos Femat, Director of Outreach, Texas Healthy Kids Corporation

The Texas Healthy Kids Corporation (THKC), a Texas nonprofit corporation, was created by an act of the 75th Legislature in 1997 as a public/private partnership to contract with licensed commercial insurance carriers to provide health insurance benefits under the program. The primary purpose of the THKC program is to provide preventive and primary health care benefits to the more than 1.3 million uninsured children in Texas.

In 1999, the Texas Healthy Kids program became available statewide. To be eligible, children must:

- be between the ages of two and 17 (up to the 18th birthday)
- have lived in Texas for at least six months
- have been uninsured for at least 90 days prior to enrollment
- not be covered by any other health plan
- be enrolled in a school or certified school program (if of school age)

The premiums for health coverage range from \$41.53 to \$79.84 per child, per month* depending on the county in which you live. Some of the benefits include immunizations, physician's office visits, well-child visits, prescription drugs, eyeglasses, lab tests, x-rays, home health services, hospitalization, basic mental health and limited treatment for chemical dependency, rehabilitation, and now, there is also an optional dental plan for an additional fee.

The benefit plan is child-oriented with age-appropriate well-child checkups that include standard vision and hearing screening at no copay if no problems needing medical care are found. Visits to a doctor (primary doctor or specialist) for vision or hearing problems are available with a low copay (\$10). Glasses are available

with a \$10 copay every two years unless the prescription or head size change. Low vision and telescopic aids are not included.

There is a Sliding-scale Premium Assistance Program to increase affordability, with family contribution reduced to \$10 monthly per child for a family of four with an annual income of less than \$25,200; and \$20 monthly per child for a family of four earning less than \$31,080. THKC cannot guarantee the availability of Premium Assistance funds which are provided through private contributions.**

Children in a family of four that earns more than \$31,080 (as well as those who may be eligible for, but choose not to participate in, Medicaid) may enroll at full premium.

To receive additional information or to get an application, call toll-free at (877) WELL KID, or consult our website at <www.txhealthykids.com>.

*Stated rates are illustrative and subject to change. Rates are identical for all eligible children in your county. Exclusions and limitations may apply to the health benefits. Insurance carriers and rates may vary by region. You must complete an application before obtaining coverage. Do not send money to Texas Healthy Kids in response to this article.

**THKC has been certified by the IRS as eligible to receive tax-deductible contributions under Section 501(c)(3) of the Internal Revenue Code.

Mailing List: Somebody Please Help

By Kate Moss, SEE/HEAR Editor in Chief

If you are reading this newsletter in either an English, Spanish, large print, disk, or audio tape version, chances are you are on our mailing list. My question to you is, “Do you want to be on our mailing list?” Each year our mailing list grows, and we couldn’t be more delighted. With approximately 7,000 copies of the newsletter going out around the state, nation, and even the world, however, mailing costs are becoming prohibitive. Now in the interest of dollars and trees, I know that all of you are asking, “So what can I do to help?”

1. If you have Internet access, would you consider accessing SEE/HEAR via our website? You can download and print all the articles or save them to disk for a rainy day’s read. If you live in another state or country, accessing the newsletter on our website would be a big help.
2. Are you receiving multiple copies of the newsletter? Sometimes you are listed on our mailing list twice by different names (e.g. Jim and J.L.) or at different addresses (e.g. work and home). We would like to send you only one copy of the newsletter and let you photocopy any extra copies you might want to share. Also, if you find you are sharing articles with the same person(s) several times in a row, maybe they should be on our mailing list or accessing it from the website.
3. Are you moving or planning to move soon? Let us know and we can make that change of address. We don’t want to waste trees by continuing to mail to an address that is not accurate.

If you have not yet received a card to update your name on our mailing list, one should arrive soon. If we don’t get the card back, your address will be deleted from our mailing list. Before you get this card, think about whether or not you need to be on our mailing list. You may prefer to access the newsletter over the Internet. If you do want to continue to receive a paper, disk or audio version of the newsletter, be sure to complete the card right away and return it to us. Remember, the only good mailing list is an accurate mailing list.

Overview of 76th Legislature From TCB Perspective

By Ken Whalen, Coordinator of Intergovernmental Affairs

The good news from the 76th session of the Texas Legislature is that services the Texas Commission for the Blind provides to blind Texans will be maintained at or above the current levels. While TCB did not get everything it wanted in dealing with the Sunset process and securing state funding, it was a successful session overall.

Following is a look at legislation that will affect the agency most over the next two-year cycle.

HB2641 -- HHSC SUNSET BILL

The bill to continue the operations of the Health and Human Services Commission represents a sea of change in the administration of health and human services agencies in Texas. HB2641 gives the HHSC commissioner control over the administrative functions of 12 state agencies that represent a third of the state's workforce.

The delivery of services will likely not be affected by this legislation, which is an attempt to improve efficiencies and cooperation between the HHS agencies. The commissioner will have control over key business functions that include purchasing, technology resources, administrative support, and accounting.

The first step for each HHS agency is to enter into memoranda of understanding between the commissioner and the agency board and the commissioner and the agency executive director. Those memoranda will determine how much control the commissioner exerts over the agency's business functions.

HB1400 --TCB SUNSET BILL

HB1400 continues TCB for another 12 years while incorporating changes suggested by the Sunset staff and agency staff. Medicaid case management and rate-setting are two areas that deal with service delivery that are affected by the bill. TCB will be required to emphasize Medicaid eligibility of consumers and use Medicaid guidelines in setting rates. The bill also requires the agency to formalize its service delivery policies by rule. The agency recommended changes like allowing background checks of potential employees, assuring the confidentiality of children's program files, and establishing the Business Enterprise Program retirement program as a trust fund. These changes were adopted in the bill.

HB2 -- GENERAL APPROPRIATIONS ACT

TCB's overall budget, which includes state and federal funds, was increased from \$42.4 million in '98-'99 to \$48.4 million in the coming biennium. The employee cap was also raised from 610.5 to 618.5.

Most of the budget increase comes from receiving more federal funds, increases of \$250,000 over current levels in both the Independent Living and Children's programs, and funds from the Blindness Education, Screening and Treatment Program. BEST funds, which are generated through a \$1 donation when renewing a drivers license, are projected to total \$1.9 million.

HB633 -- TRANSFER OF ASSISTIVE TECHNOLOGY

This bill will allow students in public schools to take their assistive technology devices with them when they transfer between school districts. Currently, these devices, such as computers and accompanying software, belong to the district. The Texas Education Agency will write rules for the sale, lease, loan or gift of the device.

CLASSIFIED

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.

Through Your Child's Eyes

Have you ever wondered how your child "sees" the world? Have you ever considered what a world with little or no sight might be like? If these questions seem important to you, then Through Your Child's Eyes was designed with you in mind. At this workshop you will have the opportunity to:

- meet other parents of children with visual impairments and deafblindness
- learn how the eye works and how your child's visual impairment impacts his vision
- participate in activities that simulate visual impairments
- learn about the resources available to you and your child
- learn about advocating for quality programming for your child
- meet adults who have visual impairments

Target audience: Parents of young or recently diagnosed children with visual impairments, including multiple impairments. This workshop has been scheduled in the following locations:

Ft. Worth: September 17 - 19, 1999

Contact: Judy Hamilton at TCB
Phone: (817) 926-4646

Rio Grande Valley: October 15 - 17, 1999

Contact: Norma Castillo at TCB
Phone: (956) 423-9411

Corpus Christi: November 5 - 7, 1999

Contact: Joyce West at Region II ESC
Phone: (361) 561-8524

This workshop is also planned for the
**Winter/Spring of 2000
in Waco and Victoria.**

It's the 25th Anniversary of the
**Deaf-Blind Multihandicapped
Association of Texas**

and

the 27th Annual Family Conference!
Please come and join us as we celebrate
**Where We've Been, Where We Are,
and Where We're Going!**

October 8 - 10, 1999

Camp John Marc near Meridian, TX

This is a conference for the whole family. There is travel and registration assistance available to help families attend. Registration information and more details about this year's event will be included in the August edition of In Touch. If you do not receive the DBMAT newsletter and want more information, please contact Pat McCallum at
Phone: (972) 287-1904 or
E-mail: DBMATpjm@aol.com.

Fall 1999

INSITE Training Waco, Texas

September 27 and 28,

October 26 and 27,

November 17 and 18

For more information, contact Tina Herzberg
at Region XII Education Service Center
(254) 666-0707, extension 260.

Southwest Orientation and Mobility Association

SWOMA Conference

Lubbock, Texas

November 12-14, 1999

Contact: Jim Durkel
durkel_j@tsb1.tsbvi.edu
(512) 206-9270

SEE/HEAR

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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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