

# **International Journal of Special Education**

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- Specialized Centres and the Local Home Community:  
Children with Disabilities Need Them Both
- Japanese and American Special Education: A World  
Apart
- Zimbabwe: Emerging Problems of Education and  
Special Education
- Meeting Special Needs in Mainstream Schools:  
A Transatlantic Perspective
- Special Education in Malaysia: A Critique
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# International Journal of Special Education

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# International Journal of Special Education

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## **SPECIALIZED CENTRES AND THE LOCAL HOME COMMUNITY: CHILDREN WITH DISABILITIES NEED THEM BOTH**

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*Two broad approaches to the provision of services for disabled persons are distinguished: The Specialized Centre Approach (sometimes known as IBR), and the Local Home Community Approach (sometimes known as CBR). Each approach is seen as having certain distinctive strengths and weaknesses and may be regarded as affording certain valuable opportunities as well as incurring certain risks.*

*A progressive strategy is proposed which combines the two approaches selectively and builds on their respective strengths, especially where one seems to respond directly to a weakness of the other. This includes the injection of greater economic realism into the equipment of specialist centres and the design of advanced training programmes; higher priority for the provision of reliable transportation; more outreach and follow-up activities by the staff of specialist centres, especially during school holidays and after clients have graduated; and redefinition of specialist staff responsibilities with greater emphasis on delegation, training and monitoring.*

Services for disabled children are relatively scarce in Third World countries. Recently a debate has emerged regarding the best strategy for their expansion. The approach advocated by the World Health Organization (Helander, Mendis and Nelson, 1980, 1984) and the International Labour Organization is known as "Community-Based Rehabilitation" (CBR). Some authors have presented

this approach as a radical alternative to the mode of professional activity exported from Europe during the first part of this century to many Third World countries, which they term "Institutionally-Based Rehabilitation" (IBR). Many of the professionals involved in what has been called IBR would not wish to describe the services they offer as 'institutional'. A less biased and, I believe, more appropriate name for their approach is *the specialized centre approach*. For reasons which will become clear later in this paper, I would also prefer a different name for CBR, namely *the local home community approach*. The main contrast between these two approaches consists of who delivers the front-line service to the client. In the specialized centre (IBR) approach, services are provided directly (or 'hands-on') by specialists to clients who attend centralized facilities for that purpose. In the local home community (CBR) approach, services are provided by members of the client's family and neighbourhood, within the context of the client's local home community and with professional support.

Most countries in the world by the 1970s had established some kind of specialized provision for the medical, educational and social (re) habilitation of children with various kinds of disability. The scale on which such provision exists in a given country is closely correlated with the nation's overall economic wealth (Werner-Putnam, 1979). In many of the poorer countries of the Third World provisions have until recently been confined to a handful of hospitals and residential special schools for blind or deaf children, which collectively catered for a tiny proportion of the nation's disabled children (Serpell, 1982; UNESCO, 1985). During the International Year of Disabled Persons (1981) many governmental and non-governmental organizations were established with a mandate to improve the existing situation. One of the themes which has received a great deal of attention from these bodies has been the relative merits of approaches based on the existing specialized centres and approaches based in the client's local home community (Nabuzoka, 1985b). This paper will examine some of the salient strengths and weaknesses of these two contrasting approaches. The purpose of the exposition is not to advance arguments in favour of selecting one of two mutually exclusive alternatives. Rather I shall argue that their respective strengths are complementary to one another, and that a progressive strategy should identify ways of combining them so that the strengths of each approach are applied as correctives to the weaknesses of the other.

***The specialized centre approach***

In some of the literature on this topic, the specialized centre (IBR) approach is also called “the traditional approach”. This usage is counter-intuitive for many audiences in Zambia and elsewhere in Africa, since they regard the local home community as having been traditionally responsible in African cultures for the care and welfare of disabled persons (Serpell, 1983). The allusion is, of course, not to an African tradition, but to a tradition developed in Europe in the 18th and 19th centuries. Like many traditions, the specialized centre or institutional approach has accumulated over the years a great deal of wisdom. This body of *deep technical knowledge* is its greatest strength. A number of dramatically effective types of intervention have emerged from research in this specialized tradition — e.g. cataract surgery to restore sight to certain blind people, electronic hearing-aids to restore hearing to certain deaf people, spinal cord surgery to release certain chronic contractures of the legs, selective diets to prevent the onset of brain damage and intellectual disability in certain conditions such as PKU (phenylketonuria). However, the *equipment* and *training* needed to diagnose and/or to treat these conditions are very expensive and can only affordably be deployed in countries like Zambia at centralized locations. Thus the deep technical knowledge which makes possible these ‘miracles of modern science’ comes at a price. And in a Third World country especially in periods of economic recession, this price must be regarded as a weakness (see Table 1).

In addition to the costs of advanced training and high technology equipment, a further problem arises from the separation which this specialist approach tends to emphasize between technical knowledge and the wisdom and common sense of ordinary men and women. The genuine expertise of the specialist becomes surrounded with a *mystique* which conceals the important fact that parts of it can be passed on as usable techniques to a ‘lay-person’ with much more limited training.

Not only do specialists tend to become cut off from ordinary people, but they also tend to cut themselves off from their professional colleagues. ENT surgeons, ophthalmologists, orthopedic surgeons and psychiatrists interact far less with one another than is in the interest of their clients, and they scarcely ever read one another’s specialized technical journals. Such *narrow specialization* is not confined to the medical professions. At a recent seminar for special education inspectors and curriculum developers in south-eastern Africa (Serpell &

Jonsson, 1986), I was saddened to hear specialist teachers of the blind and teachers of the intellectually disabled denying either a knowledge of or an interest in one another's field of competence. This kind of narrowness is not merely paradoxical given the small numbers of professional special educators in the region. The seminar also recognized that it constitutes a weakness in the service system, since it sometimes leads to 'buck-passing' with schools for the blind rejecting certain aspiring pupils on the grounds that they are intellectually disabled and therefore 'belong elsewhere', while special classes for the intellectually disabled may also turn away such multiply handicapped children on the grounds that the teacher does not feel competent to manage a blind child's problems. In fact there is a tendency for the needs of multiply handicapped children to be neglected in the region because these clients tend to 'fall between two stools' of different professional specializations.

However, specialized centres have many other strengths. The well-trained specialist teacher brings to his or her relationships with a client not only a deep body of knowledge, but also a *confidence* that the techniques he or she will apply can and do work for enabling disabled children to become more competent. They have seen these techniques at work and the results they can achieve. The confidence which this inspires is infectious and many disabled children come to believe in themselves as a result of their teacher's evident *optimistic* belief in their capacity for progress.

Another advantage of the specialized centre approach is that the professionals who deliver services are full-time staff whose responsibility for this work is formally recognized in their terms of employment. Typically they are accountable to their employers for doing their work conscientiously and regularly, and they receive *rewards* of various kinds for doing so. These may be financial rewards in the form of a salary or less tangible, but nonetheless real, social rewards such as a sense of vocational fulfilment. On the other hand some observers have pointed out that the kind of *clinical* relationship which this type of professional commitment generates is necessarily less personal, more detached (some would say colder) than the relationships which obtain between children and members of their own families.

Within an institution or centre there is normally room for several professionals and their work often benefits from collaboration. As colleagues they give one another *mutual support*, each "on his toes", or even more helpfully by sharing professional problems and suggesting to one another alternative ways of tackling them. The institution also *accumulates* a collective body of *experience*

through this exchange of ideas and this is available for new members of staff to draw on in the form of an institutional history and a professional sub-culture. These shared resources often give a special school or local hospital very positive qualities as a community of people with shared values — at best such a *special community* can generate a uniquely harmonious working atmosphere with a high moral tone which forms the basis for life-long commitments of friendship and loyalty.

Membership of such a special community usually enables disabled pupils to develop a *comradeship* with other people of the same age with similar disabilities. Although such in-group feelings may be regarded by some people as an obstacle to full social integration, many members of self-advocacy organizations of adult disabled persons regard the feeling of belonging to such a group as an important moral and political strength in their struggle to secure their rights in the wider society. The “other side of the coin” is, of course, that membership of a special community may tend to *isolate* the pupils from *normal life* in the local home community into which they were born and to which society may eventually expect them to return. The definition of what constitutes normal life is, however, highly problematic and some people who have benefitted from life in a special school community may regard their quality of life there as having been more normal than anything they have ever experienced as a single disabled member of their local home community.

Benefits which have been claimed for the specialized centre approach also include *protection from abuse* by unfriendly members of the local home community. Such abuse and prejudiced attitudes towards disabled persons are not unknown in Zambia, although they tend to be less pronounced among people who have regular contact with disabled persons (Phiri, 1979). Even families which are supportive and devoted to their disabled child sometimes express a need for periodic relief from the burden of continuous care (Dupont, 1980; Sell, 1983). Many specialized centres are well-placed to provide such relief.

A more controversial strength of special centres is their *visibility*. On the one hand a concrete building which is reserved for the use of disabled persons is solid evidence of achievement, which helps to satisfy some charitable funding agencies that their donations have been well spent. Even support groups which have little money to offer may derive some satisfaction from having a building of their own as a symbol to point to. On the other hand it can be argued that residence in a special institution is a source of special *stigma* — a mark which the disabled person is forced to carry with them throughout life and which



becomes a label that dominates people's perception of them rather than recognizing their individuality (Goffman, 1961; Edgerton, 1967).

**Table 1**

Strengths and Weaknesses of the Specialized Centre (IBR) Approach  
and Some of the Resulting Opportunities and Risks

STRENGTHS	WEAKNESSES
Deep technical knowledge	Dependence on advanced training
Guidance by confident optimists	Mystique of professional expertise
Rewards for commitment	Narrow specialization
Mutual staff support	Dependence on expensive equipment
Accumulation of experience	
Special community	Clinical relationships
Disabled comradeship	
Protection from abuse	Isolation from normal life
Relief of family burden	
Visibility	Stigma
OPPORTUNITIES	RISKS
Setting high targets	Elitism
Breakthroughs	Compartmentalization
Skill multiplication	Inappropriate curricula
Confidence building	Breakdowns
Public education	Dehumanization
Fund-raising	Perpetuation of public attitudes of fear, pity, etc.
	Permanent dependency
	Public complacency

Although the values attached to the various properties of the specialized centre approach I have listed may be controversial, they are all properties which are fairly characteristic of the approach as it is usually applied. Less definitive but often mentioned as probable consequences of the approach are a set of opportunities and risks shown at the bottom of Table 1.

Because of their technical knowledge and the optimism which goes with professional commitment, many special educators are inclined to set their dis-

abled pupils *high educational targets*. Even if these are not attained, they often lead to greater progress than 'laypersons' would have thought possible. The accumulation of experience in a specialized centre was almost certainly a prerequisite for the dramatic '*breakthrough*' innovations in methods which have been so effective in the education of people with disabilities, such as the invention of Braille writing for the blind (Pritchard, 1963) and the documentation of sign language for the deaf (Lane, 1976). Creating the conditions for more breakthroughs in the future is therefore another powerful argument in favour of establishing specialized centres.

At a more immediately practical level in a Third World country it has been argued that specialized centres are an ideal way of building up a body of skilled professional manpower for special education (Miles, 1985). As the number of staff at one centre expands one of them will move out and establish a new centre where he or she will recruit new people for training and so on, generating a progressive *multiplication of skills*. The opportunities for group in-service training afforded by a centre are certainly cost-effective.

The impact of receiving guidance by optimists provides, as I have noted above, opportunities for *building up the confidence* of disabled children. The unique qualities of a special community can be used to *educate members of the public* about the positive capabilities of disabled children, and this together with the visibility of a centre can be a powerful asset for charitable *fund-raising*.

A somewhat controversial risk of the specialized centre approach is its potential for *creating an elite* of high-achieving disabled individuals. To the extent that this is evidence of the successful attainment of high goals, this might be regarded as a positive outcome both in its own right and as an example for public education and for the inspiration of subsequent generations of disabled children. But since in a Third World country specialized centres necessarily cater only for a minority of eligible disabled children, these high achievers can also be seen as having used an inequitable share of limited resources at the expense of the majority who were denied a chance (McGregor, 1967). Whether the relatively fortunate, high-achieving minority are regarded as evidence of success or of distortion depends among other things on whether these elites are seen to be contributing to the welfare of other less advantaged individuals with similar disabilities.

Narrow specialization carries with it the risk of *compartmentalization* such that referrals between different professionals become very difficult and services lose the possibility of focussing coherently on a disabled person as a whole.

Another risk, peculiar to Third World countries, arising from narrow specialization and the mystique of professional expertise, is that a specialized centre may import from abroad a *curriculum quite inappropriate* to local socio-cultural or economic conditions. Training a child who has undergone orthopedic surgery to walk with calipers and to use a flush-toilet in an institution with modern fittings may turn out to be a poor preparation for life on the child's return to his village where the only comparable amenity is a pit-latrine. Similarly it can be questioned whether learning to respond in English to pictures on flash-cards is useful education for an intellectually disabled child when she returns to live with her family in a community of nomadic pastoralists (Ingstadt, 1983) or indeed subsistence farmers. This kind of ill-considered transfer of curricula from the industrialized countries seems to be a greater risk when professional expertise is allowed to cut itself off from the wisdom of common-sense (Goffman, 1961; Serpell, 1984).

Dependence on expensive equipment in a Third World country often also means dependence on foreign technology which is only partially imported. Isolated gadgets such as hearing-aids or computerized teaching-machines may be as useful as the life of their most rapidly exhausted component. Once this expires, with no technician to repair it or no spare parts available the gadget *breaks down* permanently and the rehabilitation programme which depends on it breaks down too.

If clinical relationships are as cold as some observers describe them, institutional care can be *dehumanizing* (Deliege, 1982). The risk that this will occur to some patients becomes greater when services are compartmentalized, when the patient is institutionalized on a full-time and long-stay basis and when the patient is truly isolated from normal life. The greater that isolation, the greater also will be the risks of *perpetuating public attitudes* based on ignorance. For a self-respecting disabled person, the *pity* which some charitable fund-raising programmes exploit is scarcely less distasteful than the *fear* which is often expressed towards the inmates of a closed institution.

These risks are of course not always realized, and a special community with very positive qualities can, as noted above, be used to good effect to educate the public into healthier attitudes. However, there is also a risk that a child may become totally dependent on such excellent institutional care and be virtually incapable of adapting to the demands of life back in the local home community into which she or he was born. Extreme advocates of the specialized centre approach may sometimes regard this as a legitimate outcome for children

whose families have rejected them. But it is arguable that a society which allows such *permanent dependency* to occur has failed to genuinely accept its disabled members as full persons. Whether or not such a phenomenon occurs, it is apparent that visible specialized centres are sometimes used in a rather *complacent way to justify indifference* towards disability. Expression such as "something is being done for them" or "they are the responsibility of . . ." fade almost imperceptibly into "he belongs in . . ." or "she is a Chainama case". Such labels are degrading both to the person labelled and to those applying them.

### ***The local home community approach***

Table 2 presents a somewhat shorter list of strengths and weaknesses, opportunities and risks inherent in the local home community approach. My reason for preferring this designation to 'community-based' is that, as I have explained above, one of the strengths of the specialized centre approach is its potential for creating a *special community*. The greatest strength of the local home community approach in my view is that it builds on and fosters a resource which the specialized centre approach tends to ignore and in some cases even to undermine: namely the *moral and emotional commitment* to the welfare of a disabled child that exists *within the family* into which she or he is born. The right of a disabled child to grow up as a member of that family is a starting point for the local home community approach, which is premised on the notion that the warmth and security which it can afford deserve higher priority than the impact of a professional doctor or teacher's specialized skills. Nevertheless anyone who has seen the successful application of such skills to rehabilitation must regard a lack of access to them as a disadvantage. Since disability does not select only children whose parents, relatives or neighbours have such skills, an essential weakness of the local home community approach is the relative *lack of training* of most of the people who are entrusted with the responsibility for 'hands-on' delivery of services.

Since, however, a service programme evidently aims to add something to what is already there, this essential weakness of the approach is only a starting problem or challenge to which the strategy is designed to respond. And indeed a second strength of this approach is that it deliberately sets out to impart relevant skills, knowledge and attitudes to parents and other members of a disabled child's family. An important indicator of the success of such interventions is *growth of confidence* among these members of the child's immediate social

environment in their competence to manage and overcome problems and to stimulate and guide the child's developmental progress.

A more serious weakness in this approach which becomes apparent in the process of educating parents and other family members is the *limited range of experience* they generally have of childhood disabilities. They soon become 'experts' on their own child's behaviour (Onarheim, 1983), but it is rare for them to even see other children with similar disabilities and even rarer for them to have an opportunity to try out any intervention techniques with such other children. Their access to the deep technical knowledge accumulated by the specialist centre approach is therefore somewhat indirect.

**Table 2**

Strengths and Weaknesses of the Local Home Community (CBR) Approach  
and Some of the Resulting Opportunities and Risks

STRENGTHS	WEAKNESSES
Family commitment	Limited training
Growth of parental confidence	Limited experience
Total coverage	Competing responsibilities
Focus on whole person	Dependence on transport
Community involvement	
Continuity	Limited opportunity for disabled comradeship
Economic realism	
OPPORTUNITIES	RISKS
Family taking pride	Superficial services
Full participation	Uncorrected mistakes
Public awareness	Perpetuation of low self-esteem
Normalization	
Acceptance	

Another weakness of this approach arises from the fact that very few parents or other family members are able to work full-time on rehabilitation because of the many other *responsibilities which compete for their time*. No balance sheet is available to compare the loss of rehabilitation inputs which this implies to the

loss of inputs implied by a child only attending school 5 days per week, 6 hours per day and sharing the attention of a specialist teacher with 8 or more other disabled children. Nevertheless some critics of the CBR approach have argued that it places heavy, and perhaps unreasonable, demands on parents in poor communities of the Third World (Kalumba, 1982; Miles, 1985).

For planners one of the most attractive strengths of the local community approach has been that it virtually guarantees *total coverage* of the disabled population from the outset. In our Zambian situation this point can be expressed in another way by noting that all of the disabled children who at present are unable to benefit from the services of one of our few specialized centres are already living in some kind of local home community. In that setting the child may be receiving little or no special help to ameliorate the disability, but the child is housed and clothed and fed and is within the immediate daily reach of a number of potential 'agents' of rehabilitation in that existing context. The challenge for a planner thus becomes to find ways of supporting and enriching the inputs of the local home community to which each child already has access. Among the various difficulties which have been encountered in applying this approach by the two pilot projects in Katete and Zambezi districts the one which stands out most clearly has been that of finding *transport to reach these local home communities* scattered throughout the District (Nabuzoka, 1985).

Other important strengths of the local home community approach arise from the nature of a natural family's perspective on the task of rehabilitation. The disabled child always remains in the eyes of his own family first and foremost a *whole person*. There is little scope in this context for the conceptual narrowing that tends to follow from professional specialization: the child's needs are therefore not fragmented or compartmentalized. Since rehabilitation is mainly embedded in the context of daily activities, this approach has the added strength of providing many opportunities for *involving other members of the local community*, which not only serves to spread the burden of care across a number of people but also provides public education through supportive participation — a method which is known often to be effective in promoting positive attitudes (Ashmore, 1970).

This involvement of the community in a child's rehabilitation has the added advantage of ensuring *continuity* between the context of learning and the context in which the skills and knowledge acquired are to be applied. For children with intellectual disability this is a major technical strength since the transfer of



learning from one situation to another is known to be a source of difficulty for these children (Bluma et al., 1976; Kiernan, 1985). A second kind of *continuity* is built into the local home community approach: this is between the worlds of childhood and adulthood. The risk of inappropriate curricula is greatly reduced in the situation where a child's social and cultural education is received in the very context for which it is intended to prepare them.

Finally a programme which places the central responsibility for rehabilitation on the child's immediate family and local community is probably less likely to embark on activities which cannot be sustained because they are unaffordable. The large concentrations of resources, which are sometimes misallocated within institutional budgets to items like equipment which cannot be maintained, simply do not occur in the budget of most individual households or small local communities. To cite as a strength of the local home community approach the greater likelihood of *economic realism* is not the same as citing affordability. The question of whether IBR or CBR is more cost-effective has been the subject of some controversy (Helander et al., 1980; Miles, 1985). It seems clear, however, that CBR has a number of economic attractions as a gradualist approach which aims at egalitarian distribution of available resources.

Opportunities which seem to be favoured by the local home community approach include those for the *family to take pride* in a disabled member as someone to whose achievements they have made an active contribution, and for *fuller participation* by the disabled individual in the mainstream life of society. This in turn creates opportunities for greater *public awareness* of the capabilities of disabled people and of their needs. The principle of *normalization* has received a good deal of publicity as a theme in modern rehabilitation philosophy (Perske, 1977): the right of a disabled person to lead as normal a life as possible seems to be well recognized in the local home community approach, although, as I noted above, the definition of normality is somewhat controversial. To the extent that this normalization is achieved together with public awareness, the *social acceptance* of a disabled individual is presumably more successfully guaranteed.

One opportunity which is *less* present in the local community approach than in specialized centres is that of forming *comradeship with other people with similar disabilities*, and this can be regarded as a weakness. This in turn may lead to a greater risk of *perpetuating the low self-esteem* which some disabled children develop as a result of being exposed to invidious comparisons with their more able peers. Two other risks arise from the difficulty of supervising a

widely diffused network of individual home-based programmes. The services may tend to be more nominal than substantive and thus to have only a *superficial impact on the client's welfare*. Still more serious is the possibility that a well meaning member of the family or neighbourhood may because of inadequate training embark on a course of action which is actually counter-productive as a result of a misunderstanding. Such *mistakes may sometimes remain uncorrected* for a long period of time if the logistics of travel make frequent, regular supervision impossible.

### ***Towards a synthesis of the two approaches***

The various advantages and disadvantages listed in Tables 1 and 2 show that neither of the two approaches I have described holds a fool-proof solution to all the problems of disability service delivery. What I now wish to suggest is that a healthy and progressive strategy should combine the two approaches selectively and seek ways of building on their respective strenghts, especially where one seems to respond directly to a weakness of the other approach. Table 3 presents a list of complementary strengths characteristics of the two approaches which seem to have the potential for correcting mutually some of each other's notable weaknesses. In order to restrain my speculations within realistic bounds much of the argument will be phrased in terms of what can be done in Zambia. Readers familiar with other country situations will need to gauge which parts of the argument are applicable elsewhere in the Third World.

Beginning on an economic plane, I would suggest that planners should attempt to inject into the financing of specialist centres some of the economic realism which is characteristic of the local home community approach. Given their present shortage of materials and human resources for the production and maintenance of modern technological artefacts, Third World nations should not import from abroad at high prices (nor indeed with generous foreign grants) equipment for their specialist centres which is liable to break down unpredictably and undermine a pattern of services designed to rely on such equipment. Third World nations should also be extremely cautious in their programmes for advanced training. The numbers of personnel to whom they allocate opportunities to train as specialists should be restricted to a realistic level in relation to the job market. Career structures should be identified as part of a realistic manpower training strategy so that the specialists who do receive advanced training are deployed in ways which put their skills to use in an effective way.



One of the implications of this perspective for the terms of reference of professional appointments is the need to emphasize that one of their major responsibilities is to pass on technical skills and knowledge to the parents and other family members of disabled children, so that they can grow in confidence of their ability to make a positive impact on their child's development. (Serpell, 1984; Mittler & Serpell, 1985). Another implication is that specialist personnel should be required to collaborate closely with the professionals of other specialities, and should be oriented in their training towards such interdisciplinary collaboration. Indeed the central focus of clinical and pedagogical training should be on the client child or adult as a whole person.

**Table 3**

Mutual Correctives of the Specialized Centre  
and Local Home Community Approaches

Weaknesses in the (IBR) specialized centre approach	Strengths in the (CBR) local home community approach
Dependence on advanced training	Economic realism
Dependence on expensive equipment	Growth of parental confidence
Mystique of professional expertise	Focus on the whole person
Narrow specialization	Community involvement
Clinical relationships	Opportunities for acceptance
Isolation from normal life	
Stigma	
Weaknesses in the (CBR) local home community approach	Strengths in the (IBR) specialized centre approach
Limited training	Deep technical knowledge
Limited experience	Mutual staff support
Competing responsibilities	Accumulation of experience
Limited opportunities for disabled comradeship	Special community
Dependence on transport	Disabled comradeship
	Visibility
	fund-raising

The practices of specialized centres also stand to benefit from some of the strengths of the local home community approach. Instead of emphasizing the protection of children from abuse and the relief of families from the burden of care, they should seek ways of involving the community in the habilitation of disabled children. Most of the pupils who attend residential special schools in Zambia go home for the holidays. These periodic returns to their local home community offer a number of opportunities, e.g. for testing and ensuring the relevance of the school curriculum to the demands of daily living at home, for recruiting parents and siblings as homework tutors, for pre-vocational apprenticeships with the owners and managers of local small-scale enterprises, for participation in local recreational activities, etc. Some of these things may occur without any direct encouragement from school, but to the extent that the school does provide support for them it may help to transform its own public image from a remote and rather strange institution into a constructive force for the community as a whole. In this way association of a child with the specialized centre could become less of a disadvantageous source of stigma than a prestigious credential which actually facilitates the child's acceptance as a valuable member of the local community.

These and other opportunities for reducing the isolation of specialized centres from the communities they serve are well-known to the advocates of local community centres (Miles, 1985). In most of Zambia's rural communities where the population density is low it may be difficult to achieve the necessary economics of scale to make small local centres viable. But with some limited investment in transport amenities and a corresponding adjustment of priorities among the various duties a staff member is called upon to perform, it may be possible to build such outreach and follow-up activities into the programmes of our more centralized, residential schools.

In the bottom half of Table 3 I have grouped together three notable weaknesses of the local home community approach: the limited training in rehabilitation available to most parents and families of disabled children, the limited range of experience many can acquire of managing and ameliorating disabilities, and the many other responsibilities which must compete for their time against the demands of rehabilitation work. The specialized centres have important resources at their disposal for counteracting all of these weaknesses: they have access to the scientific and technical knowledge of the rehabilitation professions, a vast fund of experience in its application to the various special needs of Zambian children with disabilities, and teams of professionals who are

already in the business of refining one another's work through a mutually supportive critical exchange of ideas. It should be possible to channel some of these powerful resources out into the families and communities which have the responsibility for daily care of most of the nation's disabled children.

The key principle for doing so is one which Peter Mittler has called "giving away skills". Professionals must come to shift some of their attention from the 'hands-on' practice of clinical and instructional interventions to the training of others to do this work: not only nurses and teaching aides on the staff of the specialized centres but also parents, siblings and grandparents who escort a disabled child to the centre. And in order to take seriously this side of their work, professionals must create time in their schedules to get out of their centres and visit their clients in their local home communities, so that they can identify the best trainees—people with the opportunities and the motivation to apply the skills they want "to give away". Members of a child's immediate family will always be important candidates for this outreach training, but often they will need back-up. A local primary school teacher or health worker or social development worker may be available to learn the principles of a technique alongside the family member. This local paraprofessional colleague will often be a willing ally of the visiting, specialized professional: keen to learn a new technique, quick to understand the underlying principles and willing to provide occasional advice and reassurance to the 'lay' family member who will carry out the daily work. Three types of activity are required of the specialized professional in this context: *delegation* of responsibilities; *training* in techniques (and explanation of principles); and *monitoring* the performance of the people to whom the responsibilities have been delegated in order to ensure that misunderstandings and mistakes do not remain uncorrected.

The strategy I have outlined so far fails to address one major weakness of the local home community approach: the limited opportunities which it provides for children with disabilities to form friendships with other children of similar age with similar disabilities. If we accept the argument that such opportunities are important in building up the self-esteem and moral confidence of a developing child with disability, then ways must be sought to give more disabled children access to the special communities of the residential schools than has been possible in the past. Perhaps the concept of a 'summer school' with children from a wide catchment area coming together for a month or two could be applied using the residential facilities during school holidays.

Another less fundamental, but important, practical weakness of the local

home community approach as it has been applied in Zambia's two pilot projects has been its dependence on transport for the supervisory District team to reach client families and their local communities often enough to give substance to the service (Nabuzoka, 1985). If supervision from a District centre is considered essential, then plans for the extension of this approach to other Districts will need to give priority to the provision of adequate transport for that purpose. The linkage in this case with strengths of the specialized centre approach is more indirect. Some of these countries have already established their visibility as a resource for fund-raising. I have argued above that the quality of the services they provide could be significantly enhanced by increasing the range of their outreach and follow-up activities. If the administrators of these centres accept that argument, then they may perhaps be persuaded that some priority should be given in the allocation of their resources to securing adequate transportation to make their staff mobile. This applies not only to independent, non-governmental centres, but also to the budgeting for government services. If the importance is accepted of enabling personnel with advanced training to reach out into rural communities for delegating, training and monitoring activities, it follows that priority should be given to allocating capital funds for the procurement of vehicles and recurrent funds for travel and subsistence expenses.

In conclusion, I would like to propose three challenges confronting government administrators in developing nation-wide, community based rehabilitation services for disabled children. The first challenge arises directly from what I have been saying so far: this is to recruit rehabilitation professionals as allies in the promotion of the local home community approach. If it is true, as I have tried to show, that the strengths of this approach are complementary to those of the specialized centre approach, then there should be no competition between the advocates of the two approaches. It is well-known that many of the highly skilled and committed professionals involved in rehabilitation work in Third World countries are employed by non-governmental, religious and voluntary organizations. Zambia is no exception. We have examples of effective long-term collaboration between such organizations and Government in Zambia notably in the case of the Mission Hospitals, where cost-sharing has been achieved through a fully articulated system of dividing responsibilities and the result has been at its best, an atmosphere of mutual support and trust. There is much to learn from this experience for the development of outreach rehabilitation services in our rural areas.

The second challenge arises from the experience of earlier phases of the National Campaign to Reach Disabled Children (Parekh & Serpell, 1983). This is to share resources across Government Departments. It was no accident that the Campaign was designed as an inter-sectoral enterprise. Children with disabilities need the special skills and resources of the Ministry of Health, those of the Ministry General of Education and Culture and those of the Ministry of Labour and Social Services. Each Ministry has a unique contribution to make, without which the Campaign, and likewise long-term, nation-wide services for disabled children, could not succeed. This being so, it is natural to expect each Ministry to place such transportation resources as it has at the disposal of community-based rehabilitation activities. These activities do not need to wait for a full-time vehicle to be allocated. In both the pilot projects, the teams identified ways of 'piggy-backing' their work onto other on-going programmes (Nabuzoka, 1985a). Government vehicles, although in short supply, do travel in rural districts: for the Expanded Programme of Immunization (EPI), for the School Health Programme, for primary and secondary school inspection, for supervisory visits to Adult Literacy classes and Women's Clubs, and for the collection of salaries. With commitment and flexibility CBR activities can be carried out by staff travelling together with the teams who are already travelling for those other activities.

Another area for sharing resources is that of records. Records concerning disabled individuals are held by hospitals, by the Ministry of General Education and Culture, by the Department of Social Development and by the Zambia Council for the Handicapped. There is scope for much greater coordination among these record systems.

The third challenge I would like to propose is both more general and more difficult. It is to cultivate the generation of concrete local projects from the bottom up. It is paradoxical but not, I believe, entirely inappropriate that in Zambia a national workshop called together the top officials in each Ministry from all the provinces to meet in the capital for planning a programme which by definition is based in the smallest and most peripheral of the nation's communities (Nabuzoka, 1985b). Centralized planning for a decentralized programme is an activity which at worst is self-defeating, and at best must aim eventually to put itself out of business. If CBR is to succeed, the communities in which it is based must appropriate the programme and take responsibility for its management. Such self-reliance can only be achieved if communities are given genuine decision-making authority, which includes the right to learn from their

own mistakes (Korten, 1980; Werner, 1980). This means, of course, that development from "the grassroots" up is a very slow process which takes time. In order to meet the challenge of cultivating such a growth process, government administrators and professionals alike will need great patience, great diplomacy and great optimism.

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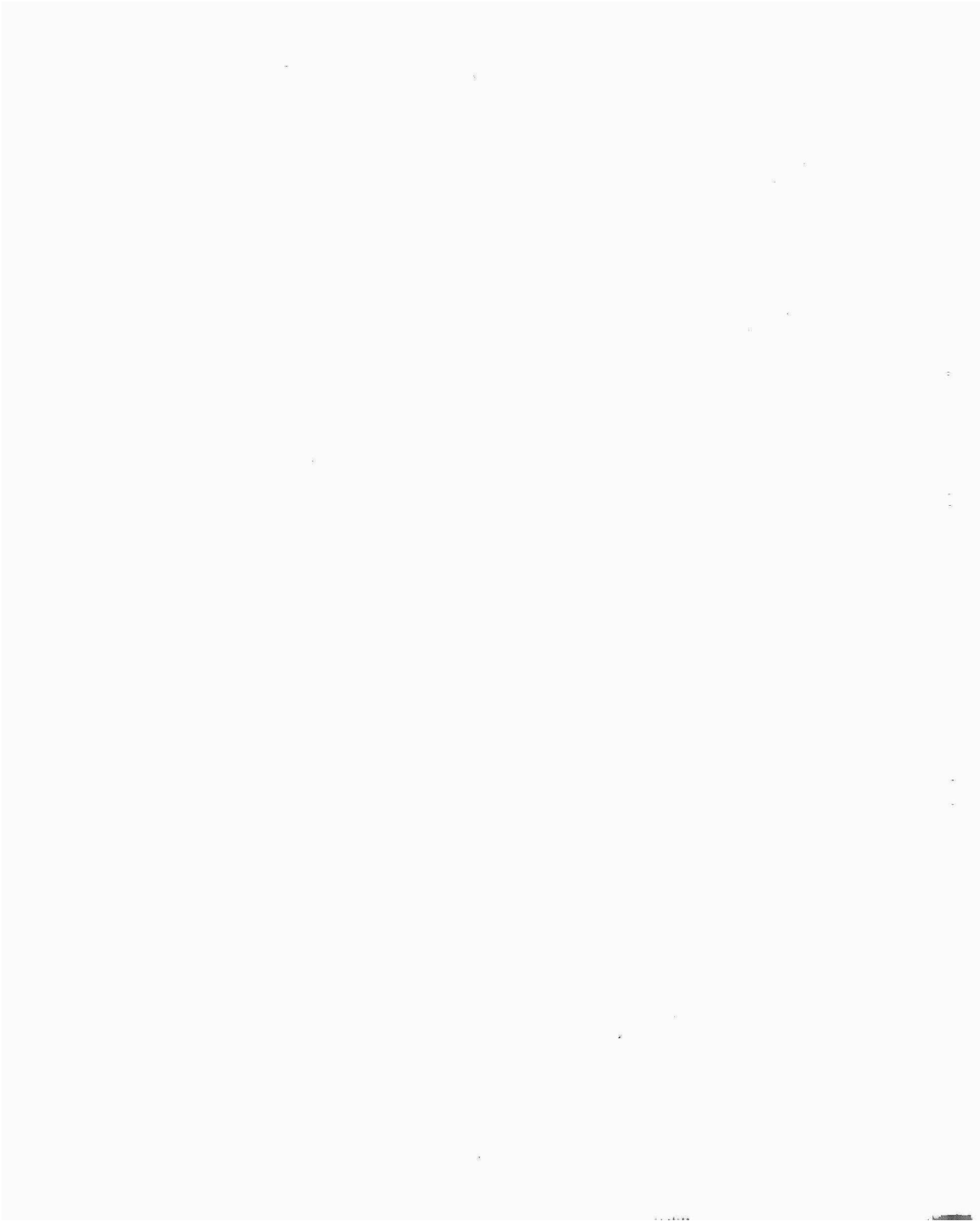


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**JAPANESE AND AMERICAN SPECIAL EDUCATION:  
A WORLD APART**

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*This article presents an historical to contemporary perspective on special education in Japan, and contrasts that system with specific components of the American special education system. Differences are highlighted in societal acceptance of the handicapped, integration into regular education, financing, parental roles, levels of governmental control and staff training. Data and impressions gathered from the authors' personal contacts with special educators in both countries are presented with an emphasis on the importance of cultural influences on educational practice. The article concludes with a contrast that illustrates the potential benefit, despite acknowledged limitations, of sharing practices across radically different cultures.*

The Japanese educational system has received laudatory media coverage in the United States over the past few years during a period of popular focus on education. However, very little, if any, attention has been paid to Japanese

special education in the popular or professional press during this period. For example, it is a little known fact that Japanese high schools exclude disruptive and slower students who are a part of the special education population in American high schools. This year is the tenth anniversary of the Education for All Handicapped Children Act (P.L. 94-142) which mandates extensive services for special needs students in American schools. How much is special education a part of the Japanese school system?

This article resulted from the authors' personal interest in Japanese culture and professional interest in the education of handicapped children. It draws on observations and information gathered during two trips to Japan as well as a review of the limited research available on the topic of special education in Japan. The trips to Japan included a two-week stay at Oshima Colony, a residential facility for handicapped children and adults, visits to regular and special schools in Hokkaido and Hiroshima, and interviews with teachers and municipal officials.

### ***School System Structure in Japan***

Compulsory education in Japan extends from grades one through nine in elementary (six years) and lower secondary (three years) schools, and the curriculum is standardized for the entire country by the Mombusha, the Ministry of Education, Science and Culture (Japan National University of Education, 1980, 1981, 1982). The national curriculum is also backed up by the educational channel on television so that programs supplement courses of study. The school year covers 240 days as compared to 180 days for most American systems. As analyzed in a series on Japanese education in the *New York Times* in July, 1983, the Japanese student follows a curriculum that moves faster through elementary level basics and covers more advanced material at the junior high level than most American school curricula. All textbooks must be approved by the Mombusho and major funding for compulsory education comes from the national government. A student changing residence to any part of Japan would find the same content, expectations and materials in the new community (Fiske, 1983a).

Entrance into high school is by examination with students at this point entering an academic or a vocational school or discontinuing their formal education (Rohlen, 1983). Failure on the test prevents high school entrance. There is no appeal, but one may repeat the test. The nonacademic student is absorbed into

the workforce without difficulty in a society in which all work is viewed as honorable and is respected.

Much has been written about the excessive pressure on students to do well on examinations (especially the final one for entrance into college), and on the role of the Japanese mother in overseeing the child's education ("Japan", *Time Magazine*, 1983; *Education Week*, 1985; and Fiske, 1983b). Mothers are expected to be at home to tutor their children and not to be employed outside the home. The examination system has fostered the creation of an extensive set of after-school private programs (juku) to help students cram for entrance examinations, with some students spending an extra year after high school in such cram schools in an attempt to gain access to the college of their choice.

Although there are some variations between and among schools, the Japanese public school system can accurately be characterized as a lock-step, regimented system which does not allow for individual differences, but rather expects total mastery of a unitary curriculum by all students, complete conformity to behavior standards and an unquestioning respect for teacher authority. The picture of Japanese education is really not complete, however, without a consideration of the unique historical and cultural factors that have influenced the system and the implications for students with special needs.

### ***The Development of Special Education in Japan***

There is very little available in the literature on the development of special education in Japan. The authors completed this brief historical overview from cited documents and interviews with educators in Japan (Ogamo, 1978 and 1979; Japan League, 1979).

The influence of ancient traditions and religious beliefs has impeded the development of services for the handicapped in Japan, and until recently, completely blocked recognition of a public role in meeting these needs. It is a basic tenet of Buddhism, a major component of the Japanese religious tradition, that a person's condition is determined by fate and cannot be changed by human effort. The Buddhist theory of cause and effect views a handicap as a sign of ill fortune, a punishment for having been evil in a former life.

Along with Buddhist influences, the Japanese culture places great value on conformity. Although it is impossible to determine whether this tendency developed as a result of the unracial and geographical isolation or from other historical factors, its effect on attitudes toward the handicapped is clear. The disabled individual is different from the norm and to be different in Japan is

unacceptable. Westerners tend to see each person as an independent entity, and efforts to assist the handicapped are seen as contributing to the culturally accepted value of individual independence. In Japan, a child who is different in any obvious way engenders guilt and shame to a high degree in the parents and there are documented incidents of parent-child suicide involving handicapped children. The basic expectation in Japanese society is that the problems of the child are the parents' responsibility and should be solved by the family alone. It is still common for a handicapped child to be hidden and such attitudes have hampered the development of public accommodation for the handicapped. Even today, one rarely sees a handicapped person on the streets of any Japanese city.

The history of Japanese education includes the little-known fact that unique protections for the blind were established in the year 1012 when the Emperor lost his sight. Services for the blind and deaf developed from that time and they have remained a part of the educational system in some form since that date. The formal initiation of special education in Japan was not recognized until 1878 when a special institution for the blind and deaf was established in Kyoto. Education for other types of handicaps had a brief beginning in the 1890's with the establishment of some special classes in elementary schools. The impetus for these classes was to help the students "catch up" with normal children by repeating the curriculum. However, these efforts were considered a failure and, for many subsequent years, handicapped students were exempted from school with some services provided by charities and volunteer organizations. School attendance was never made compulsory for the handicapped before World War II. Although a law called the Ordinance on National Schools passed in 1941 did contain recognition of the needs of children with handicaps other than blindness and deafness, its implementation was prevented by the War.

After the War, the Japanese educational system was re-established by the School Education Law passed in 1947. Attendance at school was made compulsory for all including the blind, the deaf, and the otherwise handicapped, the three specific special education categories still used in Japanese schools today. However, the local authority was allowed to exempt children whose attendance was made difficult "because of their invalidity, imperfect growth, or other unavoidable obstacles" (Passin, 1965, p.295). Compulsory attendance was actually applied at the time only to the blind and the deaf for whom there had been a tradition of public services. Limited resources resulted in a complete lack of facility development for children with other types of handicaps

until 1956 when a special law was passed providing central government financial assistance for buildings and teacher training for the handicapped which provided the needed impetus to start development of educational services. Finally, a law was passed in 1973 making attendance compulsory for all children regardless of handicap to become effective on April 1, 1979. This brought rapid increase in school building that is still ongoing.

### ***The Current Structure of Special Education in Japan***

Services for the handicapped in Japan today are provided either in residential institutions jointly run by the Welfare and Education Ministries, or in public schools in either a special school exclusively for the handicapped or a substantially separate special class within a regular public school building. As of May, 1981, there were 877 special schools serving 94,069 students staffed by 35,182 teachers (Saito, 1982, p.23). Of these schools, 72 were for the blind, 110 for the deaf, and 695 for the otherwise handicapped. The most recent information available for special classes within regular schools (which exist only at elementary and lower secondary levels) was for 1977 with the following breakdown reported: 21,000 classes with a total enrollment of 130,936 students of which two-thirds are categorized as mentally retarded (Ogamo, 1979, p.7). It was noted in the Mombusho Report that only one-tenth of one percent of the total number of children of compulsory school age have been permitted postponement of, or exemption from school attendance. Although most of these programs are established and run by prefectural and municipal (similar to county and local entities in the United States) boards of education, a major portion of their funding comes from the central government. Some of the special schools are attached to colleges of education and serve as training and research sites. Kindergarten is not compulsory in Japan although approximately 42.4% of children aged three to five years were enrolled in private programs as of May, 1981 (Saito, 1982, p.25). There are very few programs for special needs children at the pre-school level.

With few exceptions, the school entrance procedure at age six is the first diagnostic procedure for special needs students in Japan. Each municipal board of education prepares a list of all school-age children eligible to enter at the start of the next school year on April 1st. The board of education then holds medical examinations for each child and refers the results to the "Advisory Committee on School Attendance" which notifies the parent of the child's school assignment. For children with special needs, this Committee will usually

do more diagnostic procedures to determine an appropriate placement. The Committee is composed of a medical doctor, a psychologist, a teacher, and a local administrator. Information is sometimes obtained from the parent, but the parent does not attend the meeting and is not considered a member of the Committee. The Committee notifies the parent of the school which the special needs child will attend. There are specific criteria for placement of the blind, deaf and otherwise handicapped which the Committee is expected to apply in making school assignments for the handicapped.

The school entrance procedure for Japanese special needs children differs markedly from the American version in many ways. Federal Law 94-142 passed by the United States Congress in 1975 (with extended requirements added by many states) mandates a more extensive diagnostic and prescriptive process with required involvement of the parent. In the United States, the evaluation of a child includes not only the prior written consent of the parent, but also parental participation on the team that convenes to make decisions for the child's education, followed by parental acceptance or rejection of the individual educational plan written for the child before the placement can occur. Specific provisions exist for the parent to appeal a decision of the schools' special education staff in stages from administrative hearings to court suits. The differences between the American and Japanese procedures illustrate an important distinction that derives, at least in part, from cultural nuances. The Japanese attitude toward conformity and their unquestioning acceptance of authority results in a process that emphasizes the role of the professionals. The American attitude, derived from the value placed on unique individual differences and equality, leads to a process that includes the contribution of the parent as a required consideration in decision making for the child.

Special classes in Japanese public schools are differentiated by category of disability. Some statistics on the Hiroshima Public Schools provided below serve to illustrate the status of special education services within a city public school system (Hiroshima Board of Education, 1984, p.11).

The elementary school population in Hiroshima, a city of approximately a million people, was 95,358 with a special class enrollment of 542 which yields a special education proportion of less than one percent (0.57%) within that level. The corresponding percentage for the lower secondary level which had a total enrollment of 44,880 was almost exactly the same (0.58%) for the same period. Although specific data for the number of Hiroshima children who attended separate special schools were not available, it is clear that the percent-



age of special needs students served within the public school system in Japan is considerably lower than in the United States. For example, in Massachusetts for 1983-84, approximately 82,000 students ages 5 to 13 (or 12% of that population) received special education services. The American model, which includes full time and part-time special programs, provides a spectrum of services designed to vary with individual student needs. However, even a comparison limited to special class incidence levels confirms the significant differences: in 1983-84 Massachusetts reported an enrollment in special class type programs of 2.6% of the school population. In Japan, the strong emphasis on group conformity has prevented the development of part-time services which have been resisted especially by parents who do not want their children to be singled out as deviating from the norm by leaving a regular classroom to get special help.

**Table 1**

Special Classes in Hiroshima 1983-84

Type of disability	Elementary		Lower Secondary	
	Classes	Pupils	Classes	Pupils
Visually Handicapped	1	11	1	6
Hearing Handicapped	6	38	4	23
Mentally Handicapped	75	355	34	192
Physically Handicapped	4	28	1	6
Language Handicapped	9	60	1	3
Emotionally Handicapped	12	50	8	30
Totals	107	542	49	260

Sharp differences between the United States and Japan are also seen in the financing of special education. In Japan, parents pay a part of the expenses for instructional supplies and for the transportation of pupils to school. The central government provides approximately 47.3% of the cost of operating the public schools with the balance coming from municipal and prefectural sources. The percentages are significantly different in the United States. For example, Massachusetts Schools in the year 1983-84 averaged 59% of their revenues from local taxes, 36% from state aid, and only 5% from the federal government (Massachusetts Board of Education, 1985, p.37).



Specific training to work with the handicapped is less intensive in Japan than in the United States. Certification in special education in Japan is required only for staff in separate special schools and involves only ten or twenty credits in special courses (depending on the certificate) along with the regular teacher preparation program. Currently, training programs in the United States are moving toward requiring a master's degree in special education for working in any special setting after the acquisition of a regular teacher's certificate. Japanese special education teachers do receive a salary differential of 8%, a practice which has just about disappeared in the United States.

There is very little recognition of language/learning disabilities in Japan. The service delivery model does not include such categories as specific handicaps. The Japanese language is written using a set of phonetic symbols with totally consistent sound-symbol relationships (hiragana), in combination with Chinese characters (kanji) which are pictographic in nature and represent meanings as well as sounds. The Japanese child first learns the 48 hiragana in which any Japanese word can be written (another set of 48 similar symbols known as katakana represent the same sounds but are used to write foreign words, advertisements or other special situations). The child then learns the characters in an order dictated by the national curriculum. It is interesting to note that the Japanese child can write anything she/he can say using the phonetic script which is learned at the beginning of first grade. Learning the characters is, however, considerably more difficult and goes on through all grades. Mastery of the thousands of different symbols requires a strong visual memory for form and detail. Students who encounter problems in this area are probably the bulk of the group who do not succeed in passing the entrance test for regular high school where there is no provision for any special needs. As Rohlen states in his book on the Japanese high school, "The entire system operates as if dyslexia does not exist" (Rohen, 1983, p.116).

Special schools for the handicapped located in the cities and towns are run as a part of the public school system and some are attached to colleges of education. Their numbers grew considerably during the 1970's to meet the mandate of compulsory attendance for all children by 1979. One example is the Hakodate Special School on the northern island of Hokkaido which was built in 1976 as an adjunct to the Hokkaido Education University and which also serves as a training center for college students who plan to become teachers. It is a day school for 74 students who range in age from six to sixteen years. Classes contain from five to eight students who are developmentally

delayed. The curriculum includes basic academics in addition to daily living skills, art, music, physical education and club activities. The building is modern and well equipped with commercial and teacher-made materials.

The system of private day and residential special needs schools that exists in the United States had no direct counterpart in Japan. There are a few privately-owned schools and institutions, but they are heavily supported by public education and welfare funds. A unique private school near Tokyo, the Musashino Higashi Gakuen, claims significant success using a model of integrating handicapped and non-handicapped students. The school's founder, Dr. Kiyo Kitahara, has devised an approach she calls "Daily Life Therapy" to treat children with autism, a serious disorder involving communication, developmental and behavioral problems. Her program is a multidisciplinary approach with a heavy emphasis on a regimen of physical activity. For twenty years Dr. Kitahara has put children diagnosed as autistic through an intense program based on the physiological rhythm of development. For the first year of their attendance, the children are in classes of ten autistic children with one teacher. Then the children are moved into regular classes (the school includes grades one through nine) where the ratio is five autistic children for every 25 regular education students. This is the only school of its kind in Japan. Dr. Kitahara's theory has been criticized as unscientific and questions have been raised about her use of the label "autistic" and her definition of success. However, Dr. Kitahara attempted to refute the criticisms during a 1984 visit to the United States. She brought twenty-six autistic students from her school and they danced and played musical instruments during presentations in Massachusetts and Texas. As a part of the demonstrations, Dr. Kitahara also showed films of children illustrating before and after patterns of behavior with positive changes attributed to the Daily Life Therapy program. Dr. Kitahara is a strong proponent of mainstreaming, a mandated approach in the United States but one that is not widely accepted in Japan where, as mentioned before, the cultural emphasis is on conformity. Plans are currently being developed to establish a branch of Dr. Kitahara's school in Boston.

Residential facilities for the handicapped have developed throughout Japan in the past twenty years and some of them have developed into multiservice centers. One example is Oshima Colony located in the city of Kamiiso. It was established in 1967 as a residential facility for the mentally retarded by Ohba Shigetoshi who committed the institution to the goal of preparing the handicapped for a productive life through education. The Colony has expanded to

its current complex of 28 buildings including schools, workshops and dormitories for over 580 residents who range in age from pre-school to elderly. Recently, the Colony has begun to establish community-based services for the handicapped including a nursery school, after-care services and supervised work placements in nearby local businesses. The on-grounds schools closely resemble the programs in special classes in the United States. Some of the young residents are able to attend the special class in the public school of the nearby town. The most severely involved students at the Colony are in a special unit that was built for 40 autistic adolescents in 1978. Their daily schedule includes assisting in caring for their rooms and other daily living skills combined with attendance at school for the ones who can participate in a class setting. The Japanese administrators have visited the United States and other countries to help them plan programs for the handicapped. Since their facilities for the severely handicapped have been developed only recently, they have been able to avoid some of the mistakes made elsewhere in the past such as confining the handicapped in large, hospital-style institutions.

The central government of Japan has adopted policies to facilitate the transition of the handicapped from school to work. A "Law for the Promotion of the Physically Handicapped" was amended in 1976 to require private industries above a certain size as well as local and central governmental units to set aside certain portions of jobs for the blind, the deaf and the physically handicapped (Organization for Economic Co-operation and Development, 1980, p.24). According to the Ministry of Labor Handbook for 1978, the percentages range from 1.5% in private industries to 1.9% in government offices. The law also provides that those not achieving the expected ratio are required to contribute a certain amount of funds which are then re-allocated either to those "over-achieving" the ratio or for use in renovating facilities to accommodate the handicapped. Vocational training services are also mandated by this law with initial subsidies for those who employ the mentally or physically handicapped at the request of the local employment office. Stipends are also available for employers who allow their premises to be used for work experience programs. This effort is considerably more organized and comprehensive than similar programs in the United States which has focused on social service agencies and have been limited to local attempts to meet employment needs or subsidy programs supported by special associations. This difference clearly illustrates the stronger central government control which exists in Japan affecting all aspects of Japanese life including education.

Although constrained by cultural expectations, Japanese parents of handicapped children have organized some self-help groups to obtain services for their children. The Tokyo Metropolitan Parents Association for the Mentally Retarded was started in 1964 and it has successfully fostered the development of special classes and other services for handicapped children (Japan League, 1981, p.247). The members' most recent concern is the care of their children when the parents are no longer able to manage them. Parent groups in Japan have involved only limited activism and there is no identifiable group of parent/child advocates such as those that exist in the United States. In addition, the Japanese society is radically different in its approach to litigation. While American laws provide for court redress for parents who disagree with school officials on services for their handicapped children, litigious remedies are not a part of the Japanese system. The Japanese law is based on "social harmony, not personal justice" and involvement with a court of law is viewed as a public embarrassment to be avoided at any cost (*Time Magazine*, 1983, p.64). The American attitude is the direct opposite and, in fact, an extensive body of law around the rights of the handicapped has developed in the United States.

### **Conclusion**

Education of the handicapped consumes an important percentage of public school budgets in the United States and, recently, a growing proportion of educational funding in Japan. The American system can rightfully claim recognition for significant improvements in special education that have facilitated the development of individual potential. Japanese educators also point with pride to their rapid expansion of facilities and services in recent years. A comparison of the two countries reveals the essential role of culture in the development, content and approach to accommodating different student needs. Rapidly improving means of communication are allowing educators to borrow and adapt approaches for all kinds of students and to share educational techniques between countries with radically different cultures. Some strategies can be borrowed or adopted while other aspects of one country's program may not fit in another country. For example, the major emphasis in the United States on "least restrictive environment" requires that a handicapped child be placed in the regular education setting to the maximum extent feasible. Such an approach has little acceptance in Japan where cultural values stress conformity and mitigate against the development of instructional services that

result in identifying a child as different but which are necessary to support the mainstreaming concept.

As with all aspects of education, there is no "one best way" to educate special needs students. Educators have an obligation to continue to search for improvements and to share with others those aspects of structure, management and program implementation that yield success. It is to further that good that this article was written and it is hoped by the authors that it will encourage the further exploration of special education issues among all educators.

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**ZIMBABWE:  
EMERGING PROBLEMS OF EDUCATION  
AND SPECIAL EDUCATION**

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*At the time of the independence the main thrust of the system of education was to remove former racial barriers and throw the doors open to every citizen. The task of desegregation and expansion has absorbed so much of the energy and effort that the core questions of what type of education, what model of delivery would suit the country's economy have not been addressed. The number of handicapped children receiving education is very limited. There appears to be no national policy for special education. The Swedish International Development Agency (SIDA) in cooperation with the Ministry of Education of Zimbabwe is about to lay the cornerstone of a national special education program.*

In 1986 Zimbabwe celebrates its sixth year of independence from colonial rule. The post-independence years have witnessed a new era in education. The problems of the unprecedented expansion of elementary and secondary enrolment, the teacher training and adult literacy, as well as the recent plans for the development of special education and rehabilitation of the handicapped can be best understood within an historical context. The roots of the present system, as well as many of its problems, stem from the inherited colonial practices of education, which at the time of independence were embraced by millions of



new students without a radical transformation and without any critical evaluation as to their suitability for the needs of the new socio-political and economic order. Kadham and Riddell (1981) warned that the appeal to expand the former system of education, to give more blacks the type of education they had seen whites receive during the colonial days, would benefit only a small proportion of the population, would lead to waste of scarce economic resource, and would not remove the ingredients of poverty. Yet the lure of the education which led whites formerly to positions of power was aspired to and strongly desired by millions. After six years of independence, the ties of the old system are still strong. With growing frustrations many, whose expectations could not be met, gradually realized that the removal of racialism from the system of education is not enough; fundamental changes related to the socio-economic development of Zimbabwe are needed in education which at the same time reflect the value system of Zimbabwean society. The purpose of this paper is to review past and present developments in the field of education with special attention to the emerging attempts of the education of the handicapped.

### **1. *The Colonial System of Education***

The colonial system of education in Rhodesia was designed to promote and protect the political and socio-economic interests of the whites and to control the pace of advancement of the blacks (Munzazi, 1985). Until 1979 Africans were denied equal educational opportunity. From 1890-1979 a dual system of education, one for whites (high quality, free, universal, comprehensive, and urban) and one for blacks (low standard, overcrowded, understaffed, poor, and poorly equipped) under separate ministries of education, offered two distinct avenues for schooling. Racialism manifested itself in the lack of access to school for the majority of the blacks in contrast to free universal education for whites, in a greater government expenditure on the education of whites and in the minimal number of places for further education for blacks as opposed to adequate facilities for whites (Kadhani & Riddell, 1981). A glaring example of unequal treatment is the difference in the per capita expenditure. During the 1964/65 school year, for example, the expenditure per white pupil was \$197.30, and at the same time \$18.40 per black. In the following year, 1965/66, the increase per white pupil was \$18.90, raising the per capita amount to \$206.00, while per black pupil, a mere 50 cents, the total expenditure being \$18.90 per child (Bull, 1967). A decade later the same inequality existed. By 1977/78 the average amount budgeted per white pupil was \$522.00 and



\$52.00 per black. The per capita support for whites remained ten times the amount given to blacks.

The government and the missions provided schooling during the colonial period. The government was rather slow in assuming responsibility for black schools. By 1924 1,216 missions schools catered for 77,000 black children but only one government school. Even as late as 1940, only two government schools for blacks were in existence (Kadhani & Riddell, 1981). In 1976 out of the 168 white primary schools, 150 (90%) were run by the government, but out of the 3,498 black primary schools, only 95 (3%).

Education became compulsory for whites in 1930 from age 6 to 15, and for Asians and Coloured in 1938. White education was free until 1960, but the blacks had to pay fees. The first secondary school for blacks was opened by the Anglican Church in 1939. Out of the 150 secondary schools for blacks by 1976 the government assumed responsibility for only 27 (18%), but 37 (86%) of the 43 for whites were the responsibility of the government. The Minister of African Education, Arthur P. Smith, announced new policy changes in 1966 which curtailed the opportunities for black students, making it impossible for 50% of the primary school completers to continue their education. The policy stated that no more than 12.5% of the graduates of the primary school would be enrolled in senior secondary and another 37.5% in junior secondary by 1970.

As of 1969, the government reduced spending on black primary education and paid only 5% of the teachers' salaries, expecting the parents to assume responsibility for the remaining 95% (Parliamentary Debates, September 2, 1969). The Christian mission schools, which provided 90% of schooling for blacks, relinquished control to African Councils with full financial responsibility at a time when the earnings of black parents were less than 10% that of the whites. Thus the school fees represented a great burden. Fees for secondary schools were affordable by most whites but not by Africans.

The war between 1972-79 claimed more than 200,000 lives, closed one-third of the schools (1,520 primary and 57 secondary), and increased the bitterness between races. This war, fought mainly in rural areas, affected the black population very seriously. School enrolment declined sharply and among the more than 150,000 refugees outside the country, the majority were children without any schooling or receiving a makeshift education in the refugee camps.

In addition, not all black primary schools offered grade 7 examinations: of the 3,498, only 1,974 (56%) did so. Dropout rates also differed significantly. Up to 1979, places were provided for all white children 6-16 years of age for a

7-year primary education, followed by secondary. Of the 5,471 who started school in 1968, 5,181 reached Form IV in 1978. The dropout rate of 5% was almost exclusively due to emigration. In contrast, out of the 75% of the black 7 year olds enrolled, 45% dropped out during primary school, and of the 19% (7% of the age group) who managed to enter secondary, 42% dropped out before Form IV. Less than 4% reached the sixth form. In spite of the fact that each year 36 times as many black than white children reached school age, the number in Form IV were the same (Kadhani & Riddell, 1981).

Figures for 1967-71 indicated that the opening of new schools did not keep pace with the yearly population growth of 3.5%. During this period, an average of 37,000 black children failed to find primary placement. Between 1966-76, the population of black 7 year olds entering Grade 1 fell from 84% to 72%, and between 1972-76, the number of black pupils entering secondary school from 25.7% to 20.9%. In 1970, roughly 50% of the 6-13 year olds were in school (Nelson, 1983). The numbers grew slowly but the war caused a major decline.

Furthermore, it is estimated that in 1976 about 200,000 children, 7-14 years of age who lived on white farms received little or no education at all (Kadhani & Riddell, 1981). An exception to segregation was the University of Rhodesia, established in 1955 as the University College of Rhodesia and Nyasaland. It had acquired full university standing in 1970, and Africans constituted 40% of the student body. Since independence, it is called the University of Zimbabwe.

The employment structure in line with the school system reflected the privileged position of the whites, who monopolized the skilled managerial and technical jobs. The blacks were delegated the semi- and unskilled jobs. In 1977 only 265,000 blacks were paid wages commensurate with jobs of a clerical, technical or higher category (over \$50.00 a month). Over 50% of the blacks in wage employment worked on white farms (Kadhani & Riddell, 1981). Even under these circumstances, education was closely related to economic reward by allowing blacks to escape from the subpoverty wages on the plantation and in domestic service. This was the scenario which greeted the birth of independence. As in the documentary film, *The Road to Freedom*, Herbert Chilego summed it up: "It is clear we had to fight because we were made to acquiesce to colonial education and political purposes by force" (Ministry of Information, 1983).

## **2. The Post-Independence System of Education**

The new government advocating the popular doctrine of reconstructionalism

(Templer, 1985), the theory first proposed by Dewey that "education properly organized can be one of the major forces for planned changes in society" (Skilbeck & Harris, 1976, p.34) had the immediate tasks of desegregating and expanding the inherited system of education and making plans to change its character to suit an African-dominated society (Nelson, 1983).

(a) *Expansion*

The government decided to create a unified educational system and commenced to restructure the Ministry of Education. As the first act, President Banana reopened the schools closed by the war in the rural areas and introduced free education on a phased in basis, beginning with the primary sector (Government of Zimbabwe, 1980).

Nothing reflects more the desire of the Zimbabweans to partake in the education they had seen whites receive than the dramatic increase in enrolment which can be best described as an educational explosion. Children appeared in schools by waves, and Table 1 illustrates this unprecedented growth in enrolment in 1980-84.

**Table 1**

Total primary and secondary enrolment (1980-84)\*

	1980	1984
Primary	800,000	2,400,000
Secondary	66,000	313,000

\*Edquist, 1984

Mungazi (1985) illustrated this dramatic growth as the somewhat different figures for all levels of education as shown in Table 2.

Schools had to be built rapidly to accommodate the large wave of pupils, Table 3 illustrates the number of schools from 1980 to 1983.

By 1981, the primary enrolment was the double of the 1979 figure. The secondary enrolment in 1983 was three times as much as in 1974. The primary enrolment in the second semester of 1980 was roughly 78% for the 6-12 year olds. This figure grew to 90% by 1982 (Nelson, 1983).

**Table 2**

Pre- and post-independence enrolment in educational institutions (1974-83)\*

	1974	1979	1981	1983
Primary	836,500	892,651	1,680,143	2,164,118
Secondary	66,458	72,335	144,735	188,467
College	933	1,617	2,525	3,255
Total	903,891	966,603	1,827,403	2,355,840

\*Government of Zimbabwe Monthly Report of Statistics, November 1981, p.5, and Parliamentary Debates, August 3, 1983, p.1146.

**Table 3**

Number of schools (1980-83)\*

	1980			1981		
Region	Day Schools	Secondary Schools for Ex-Refugees	Total	Government Schools	Private Schools	Total
Manicland	8	1	9	13	98	111
Mashonaland	9	2	11	55	219	274
Matebeleland	10	3	13	32	81	113
Midlands	11	1	12	33	136	169
Masvingo	9	-	9	11	112	123
Total	47	7	54	144	646	790

\*Government of Zimbabwe, 1983, and Parliamentary Debates, August 13, pp.1142-43.

The government's intention to promote "the growth of every Zimbabwean regardless of his status, sex, race, or age" (Banana, 1982, p.59) ran up against problems of declining economy, drought, and political uncertainty. In order to expand secondary education, \$1.8 billion had to be borrowed from the Inter-

national Monetary Fund and a large number of expatriate teachers had to be recruited. The secondary enrolment constituted only 8% of the 13-18 year olds, but by 1982 it rose to 22%. By July 1983, universal secondary education became available for urban students, and approximately 90% of the primary school graduates found places in high schools (Mungazi, 1985). The government also sought the aid of the U.S. Agency for Internal Development (AID) to keep up with its commitment to the education of its citizens. Pre-school education became available for about 10% of the pre-school population.

The surge in enrolment overloaded the existing physical facilities, and secondary schools operate with double sessions; boarding schools became day schools; and the need for space for primary pupils was solved by occupying the schools hitherto used for whites and by various ad hoc arrangements. As universal primary education has not been fully attained, admission is not compulsory, but a child is not denied a place (UNESCO, 1985).

Education in Zimbabwe is a joint adventure between government and private organizations, two parallel systems of education. By far the majority of schools are private, and only 10% are directly run by the government. In 1983 in Matebeleland, for example, from the 1,021 registered schools 100 were under the government. In 1983 in Matabeleland, for example, from the 1,021 registered schools 100 were under the government, 20% of the 450,000 pupils in government schools (Gordon, RMG/SH 107/1984). About 93% of the primary schools are owned and managed by up to 600 different local agencies. The Ministry of Education is directly responsible for 272 (7.2%) of primary and 148 (20.2%) of the secondary schools, which leave 3,533 primary and 582 secondary under various organizations.

(b) *Adult literacy*

In the absence of a detailed national survey, estimates of illiteracy vary from 70% (World Almanac and Book of Facts, 1983) to 90% of rural adult illiteracy (Ministry of Education and Culture, 1985). According to the 1969 Census of Population, 1.5 million blacks (40%) over age 7 had never been in school. Functionally illiterate blacks over age 7 were estimated to be 2.3 million (60%) in 1969. Between 1969-78, about a million blacks never started school. An estimated 3 million are functionally illiterate (Kadhani & Riddell, 1981). Dean (1978) gave the figures of 45% of blacks over 15 as illiterate and an additional 12% semi-literate.

The Adult Literacy Organization of Zimbabwe (ALoz), a voluntary organization, trained 15,000 illiterates between 1969 and 1976. In 1976 another 50,000 black children aged 7 failed to enter primary school. The war years made the situation progressively worse. A study commissioned by ALOZ in 1981 estimated that 40% of the adults were illiterate and another 15% semi-literate. Of the estimated 2.5 million adult illiterates in 1983, two-thirds were women.

Prime Minister Mugabe, when launching the National Adult Literacy Campaign in 1983, warned that it was impossible to achieve political and economic independence with oppressed mental processes due to lack of adequate education. The responsibility of organizing the campaign was delegated to the Minister of Community Development and Women's Affairs. Although the literacy rate increased slightly in 1983, it was still too low to allow a greater pace of national development. With a full goal of full literacy by 1988, several agencies under the National Literacy Coordinating Council were established at village, district, and provincial levels to promote literacy. ALOZ was involved with planning and development of the campaign, and is committed to ensure its success (Mugawenda, Kazembe, Monteiro, Holmes & Tshuma, 1985).

Since Independence, ALOZ trained literacy teachers both in Shona and Ndebele, supervised 400 literacy teachers with 20,000 students, developed and distributed literacy materials (booklets, teachers' guides, teaching aides), and supported literacy-related income-generating projects. After the 1981 study, ALOZ revamped its teaching program and brought it closer to the Freirian approach of conscience raising, relating learning to everyday problems. Women formed the majority of students (80%) in literacy programs (Mugawenda et al., 1985).

Grainger (1985) did a survey to find out why men shy away from literacy classes. The findings seemed to suggest that they are ashamed to show their ignorance in front of women and resent the women laughing at their wrong answers. The young teaching the old is also against traditional practices. Men claim they are busy, yet women do most of the work. The government has recruited a number of volunteer literacy teachers. District coordinators were given a motorbike by UNICEF and another incentive is the promise of easier admittance to teacher education, provided they meet admission requirements (Grainger, 1985).

(c) *Teacher Education*

The Annual Report of the Secretary for African Education (December 31,



1976) showed a wide range of pupil teacher ratios for the various types of schools, among them 1:18 for white and 1:57.5 for black primary schools. While white schools employed white teachers only, in black schools 13% of the teachers in 1977 were also white (Kadhani & Riddell, 1981). With the expansion of education commitment, teacher shortage became acute. Kadhani and Riddell (1981) estimated that to provide universal education for all black children born between 1977-83 who began their school career in 1984, 18,000 teachers would be needed at a 1:40 teacher/pupil ratio. Teacher colleges would need to increase from 11 to 24 to produce these teachers. To provide secondary education by 1990 to these children 42,000 secondary teachers at a teacher/pupil ratio of 1:20 and an additional 70 secondary teachers colleges would be needed.

The massive growth of enrolment in the primary and secondary schools required the training of a great number of teachers. As teacher training could not keep pace with the surging and immediate needs, many expatriate teachers were hired to fill the gap. To solve the pressing needs, the Zimbabwe Integrated National Teacher Education Course (ZIMTEC) colleges offer formal academic training of 16 weeks and four years of in-service training. Field tutors supervise study and practices, and courses are offered during weekends and vacation. By December 1982, there were 3,500 trainees in rural schools. It is expected that 9,000 teachers will be trained by their approach by 1987 (UNESCO, 1981). ALOZ would also require 7,000 adult literacy teachers to training the present backlog of adult illiterates over a ten year period, not counting the thousands of children who have not started classes or who have dropped out during the early primary years.

An innovative venture, the Break-through Nursery School and Child Development Teacher Training Centre staffed by women in 1983 to train women with secondary education as professional child care teachers, supervisors, and teacher trainers offer in-service training for preschool teachers. It is a private, non-profit organization, community-oriented with a full-day registered nursery school.

Primary teacher training is further complicated by language usage. From Grade 3 onward, English is the language of instruction, but in the beginning primary years it is either Shona or Ndebele. There are three official languages: Shona spoken by 80%, Ndebele by 10%, and English by 3%. Minority languages (7%) include Tonya, Venda, Tswana, and Sotho. The teacher with at least three languages is the most mobile.



### **3. Areas of Special Attention**

The Ministry of Education and Culture in partnership with the Dag Hammarskjöld Foundation adopted the recommendations in 1981 that special attention be paid to:

- the education of those children whose education was interrupted by the war,
- the education of women,
- the education of the disabled.

Opening the schools closed by the war, making primary education free, and mounting the adult literacy campaign provided major and immediate solutions to the first two of these special education areas. The education of the disabled adults and children gained special impetus by the Zimbabwe National Disability Survey.

#### *(a) Zimbabwe National Disability Survey*

In 1981, an international team surveyed a sample of 15% of the country in terms of area and population to establish the extent and causes of disabilities after the protracted war which left thousands disabled (Davies, 1983). This survey focussed on more serious forms of disability in order to determine the most pressing needs.

Eleven categories of disabilities were differentiated as listed in Table 4.

This survey concentrated almost exclusively on rural areas, and it was to be expected that the data which represent minimum incidence figures might be higher in urban settings where industrial trauma is present.

The majority of causes of disability for school age children are preventable. Table 6 gives the specific causes.

This survey highlighted major concerns; namely, that half of the handicapped are not in school, that many of the handicapped conditions are preventable, and that the disabled suffer not only from physical but from educational and vocational handicaps (Davies, 1983).

#### *(b) Special education*

The number of handicapped children receiving education is very limited. Jonsson (1982) presented the distribution of educational opportunities for handicapped pupils as shown in Table 7.

**Table 4**  
Percentage, number and category of disability\*

Percentage	Number of Disabled	Category
24%	70,000	Visually impaired (22,700 totally blind)
23%	60,000	Lower limb
12%	34,000	Upper limb
10%	27,000	MR or behaviorally disturbed
9%	23,000	Hearing (8,500 totally deaf)
8%	20,000	Speech (9,800 unable to speak)
6%	15,000	Neurological (9,800 epilepsy)
4%	10,000	Spinal
2%	5,000	Respiratory
1%	2,700	Cardio-vascular
.5%	2,500	Skin diseases
.5%	1,800	Other (acts of wild animals, snake bite, lightning strikes)
100%	271,000	

\*Davies (1983)

**Table 5**  
Category and number of disabled children

Visually impaired	10,400
Disability of lower limb	13,000
Disability of upper limb	6,700
Mental retardation and behavior disorders	6,600
Hearing impairment	5,100
Speech disability	7,700
Neurological impairment	2,600
Spinal impairment	1,300
Respiratory impairment	300
Cardiovascular impairment	100
Skin impairment	600
Other impairment	500
Total	54,900

**Table 6**

Causes of disability of school age children

Cause	Number of Children
Disease	10,700
Accident	4,100
War	900
Abnormal pregnancy, abnormal birth	1,300
Malnutrition	300
Heredity	500
Total	17,800

**Table 7**

Special education opportunities in Zimbabwe, 1982

Handicap	Number of Special Schools	Number of Special Classes	Open Education	Number of Pupils
Blind	2		10	539
Deaf	3			526
Physical handicap	3			398
Mental handicap	9			483
Slow learners		65		733
Total	17	65	10	2,679

Two years later, according to Edquist (1984), the following number of children received special education from a high percentage of untrained teachers (Table 8).

One-quarter of the teachers are trained; the other three-quarters need training. The population of Zimbabwe between 5-17 years of age is 2,224,000. If we take 10% as handicapped, 220,000 disabled children await special education in primary and secondary schools.

Jonsson (1982) highlighted the three major concerns of special education in Zimbabwe:

**Table 8**

Number of children per category of handicap,  
trained and untrained teachers in special education schools (1984)

Handicap	Number of Children	Number of Teachers	Number of Trained Teachers	Number of Untrained Teachers
Physically handicapped	398	45	13	32
Blind	437	41	3	38
Deaf	526	42	11	31
Mentally handicapped	483	49	31	18
Slow learners	783	64	7	57
Total	2,577	241	65	176

(i) *low involvement of the Ministry of Education*

The Ministry has no special section or unit designated to deal solely with special education. A quarter of the time of the chief education officer is allocated for special education. The limited involvement of the government has resulted in a number of uncoordinated, mostly urban, special schools supported by independent, charitable, private, religious, and humanitarian organizations with limited contact with the Ministry of Education. The Handbook of Social Services in Zimbabwe in 1980 listed 34 various associations under the label "handicapped".

Since 1982 the Ministry has made definite commitments in this area. The Ministry's first involvement with special education occurred in 1982. The officer appointed unfortunately left in 1984. The Ministry hopes to fill three positions by 1986 in the areas of the deaf, blind, and mentally retarded (Samkange, 1985). Later plans include the physically handicapped. Permission was granted to increase the number of special classes in regular schools to 94, pending the availability of trained staff. The government pays the teachers' salaries in part or in full, and a small per capita grant to the various groups which have maintained schools for the handicapped since 1982.

(ii) *lack of national policy on special education*

The current Education Act does not make mention of special education.

There appears to be no national policy for special education which could achieve the coordination of the existing programs.

(iii) *very few handicapped children receive education*

The dramatic expansion of involvement in primary schools since independence has tapped all available resources. Special education is provided for 2,500 children, less than 0.2% of the total school population of 1,820,000 in 1982. The existing low-scale program, mostly urban, reaches very few handicapped children, especially African children.

The Ministry plans another national survey for 1986 (Samkange, 1985) to establish types of disability, severity, location, availability of boarding schools. The basic philosophy of integration will only be realized once backup services are in place, probably 1990 or beyond. Since at present 90% of the children are in schools, it is most likely that in classes of 45-50 pupils the deaf, the blind, and the mentally retarded will sit undiscovered.

The governments of Sweden and Zimbabwe have agreed on Swedish assistance in the development of special education through the Swedish International Development Agency (SIDA) with a consultant attached to the SIDA office in Harare. The SIDA consultant, Jonsson (1982) summarized the status quo and main concerns of the existing special education programs:

- low-scale program mostly for a few white, urban children,
- financed and run by non-governmental organizations,
- no national coordination, plans or goals,
- shortage of specially trained teachers,
- deep-rooted philosophy of charity,
- no governmental organization to finance ongoing programs,
- government shortage of funds, qualifications, personnel, and academic capacity.

Three years later, the future plans of the Ministry of Education in relation to special education addressed the fundamental needs for the development and expansion of the emerging field of special education. These were:

- provision of special education teacher training for a diploma at the graduate level,
- formulation of a national policy of special education,
- appointment of special education officers at the Ministry level,

- coordination of the work of voluntary bodies,
- mounting of in-service courses for heads and teachers (Samkange, 1985).

In addition to the above, Jonsson (1982) stressed the need for overall planning, development of vocational training, and the establishment of regional resource centres. By laying the cornerstones of special education with the help of SIDA, it is expected within the next decade disabled children will be given equal educational opportunity providing the money and expertise are available.

With time the attitudes of the parents are changing and the number of people seeking formal rather than traditional help for their disabled children is increasing. The following description by Mvale (1985) illustrates the former attitudes, beliefs, and treatment among the Kalanga toward blindness. Traditionally the mother was blamed for the child's disability. It was believed that she had extramarital relations which resulted in too much blood in the reproductive system which affected the foetus. A blind child was considered born dead and he was taken to the kraal at night and had his mouth stuffed with cow dung ("ukuggiba"). If partial sight was detected, a few drops of blood and mother's milk in the baby's eyes was supposed to make a visible difference, and the newborn was allowed to live.

(c) *Special education teacher training*

One of the major problems in the way of developing special education is the lack of special educators. At the time of the independence many Eurasian special educators left the country. Special education teacher training shows little development. Most special educators were trained overseas and some teachers for the blind and deaf at Montfort College, Malawi. There is no general special education teacher training in Zimbabwe. At present the United College of Education in Bulawayo offers a one-year training course for teachers of the blind. This college could become a center for special education teacher training with suitably trained personnel. It is an expressed desire of the Teacher Training Section of the Ministry of Education to develop special education departments within the existing teacher training colleges. The number of special educators needed, if 10% of the total school population is provided with special education and if every special educator is capable of teaching 20-40 handicapped pupils, it is estimated to be 5,000-10,000 (Jonsson, 1982). In addition to training new teachers, 75% of the currently employed teachers in special education settings also need further training.

The future plans of the Ministry for teacher education (Samkange, 1985) include the establishment of one-year training courses for teachers of the mentally retarded, and teachers of the deaf by 1986-87. The Ministry plans to sponsor one course a year. The training for teachers of the blind at the United College of Education is sponsored by the Royal Society for the Blind. A diploma, B.Ed., and M.Ed. course in Remedial Education at the University of Zimbabwe is on the drawing board. A B.Ed. in Special Education is planned to supply staff to regular teachers' colleges to contribute to the basic teacher education programs to make integration possible.

(d) *Rehabilitation of the handicapped*

Only 2% of the 276,000 disabled persons identified by the National Disability Survey derive benefits from the conventional rehabilitation centres situation in urban areas. These rehabilitation services at the time of independence were highly centralized in urban areas, with British-trained personnel who tended to compartmentalize the patient's physical, occupational, and social problems and to provide services mainly in institutions (Hanekom, 1984). The enormity of the problem needed different solutions.

The National Council of Disabled Persons in Zimbabwe has established a rural grassroots development project, the Outreach Programme which contacts the rural disabled and encourages them to work together with their community, to improve their own standard of living and at the same time to make a positive contribution to their village (Nyath, 1984). A public education campaign to fully develop this program has begun. Based on the principle of community development by self-help, this program has the advantage of being cost-effective.

The Ministry of Health has made a start with the establishment of the Rehabilitation Assistants Program. Rehabilitation assistants were needed who could be trained cheaply and fast and who could work independently until more skilled persons could be trained. During their 15 months' training, they learn at a basic level anatomy, treatment techniques, community studies, psychology about specific disabling conditions, vocational training, and work in large hospitals. By 1985 under the Ministry of Health whose motto is "Health for All by the Year 2000", eighty rehabilitation assistants worked across the country, among them several disabled persons, including amputees and disabled ex-combatants. This work included beside conventional physio- and occupational therapy to in- and out-patients at hospitals, outreach work,



education of the community, promotion of disability prevention and early identification, and integration into the community (Hanekom, 1984).

Shane (1985) reported that the National Association for Care of the Handicapped (NASCOH) with a 30-member organization is recognized by the government as the official body and advisors to the government and operates approximately 80 centres assisting about 8% of those identified in the National Disability Survey three years earlier. In the interest of prevention of disability, the Ministry of Health trained some 4,000 village health workers to combat the major health problems in Zimbabwe, nutritional deficiency, communicable diseases, conditions related to pregnancy, childbirth, and the new-born period. The fall in infant mortality rate from 120 per 1,000 to 60 per 1,000 live births is believed to reflect the impact of the programs.

The Lutheran World Federation provides more than 5,000 disabled ex-combatants with skill acquisition programs.

#### **4. Observation**

Initially the thrust of the new system of education after independence was directed towards expansion without fundamental changes which led to thousands of unemployed black secondary graduates (Kadhani & Riddell, 1981). By 1985, 90% of the school-age children were in primary school. To maintain that level is a continuing uphill battle with increasing numbers of school entrants. According to the 1982 census, almost half (47.2%) of the population of 7,532,000 are under 15 years of age and the annual growth rate is over 3%. Kadhani and Riddell (1981) gave some projections to indicate the size of the problem. To give all black children born between 1977-83 a full seven years of primary education from 1984-90 would require 1,658,400 primary places; to offer four years of secondary education only to the 234,000 born in 1977, 936,000 places will be needed between 1990-94. In order to realize this and make primary education compulsory, a major economic investment to education would be required, probably to increase the level of education of the unemployed. On July 31, 1983 the government announced its intention to design a new syllabus in harmony with the country's national development plans and with its economic and social needs. A new education system is needed. Indeed Zimbabwe finds itself at the crossroads of the need for fundamental change (UNESCO, 1985). Its economic, social, educational aspirations must be reconciled with reality. Some claim that the economic system as a whole has not changed at all since independence and the "real transfer of

power or ownership of the country's resources to the people are yet to be seen'' (Mathema, McGarry, Chigudu, 1985).

The main requirements of the new education system should address itself to the eradication of educational differences between urban and rural areas and to attain universal adult literacy. The basic education system must be oriented towards productive employment in the agricultural sector, and a reformed secondary school that is not independent of the requirements for skilled labour, technical and managerial skills.

Five years after independence, the kind of education Zimbabwe needs for the future has to be formulated and realized. Perhaps the mode of education developed in the refugee camps in Botswana, Zambia and Mozambique during the war, joining practical and academic training and emphasizing self-reliance, might well form part of the new system of education. The Zimbabwe Foundation of Education with Production has a number of pilot projects trying to make the policy of education with production a reality. With the professional and financial assistance of the Swedish government, special education might become a reality during the last decade of this century. In order to develop an integrated system of special education, a far greater degree of involvement of the government, than is current, will be necessary. As a model, the extant grassroots self-help programs for the rehabilitation of the disabled might very well provide a solution for some of the problems faced by disabled children in Zimbabwe.

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## **MEETING SPECIAL NEEDS IN MAINSTREAM SCHOOLS: A TRANSATLANTIC PERSPECTIVE**

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*In keeping with our international colleagues the last decade has heralded significant changes in thinking about the education of children with special needs. In this article we introduce an approach to special education developed by one local authority in England. Some of the main features of this approach, which has now been disseminated widely in England and Wales, are examined.*

### **Background**

In recent years there has been an increase in concern about meeting special educational needs in ordinary schools. Changes in attitude in this country have occurred for a variety of reasons which include:

- (a) *The 'rights' movement.* Parents have become more vocal in stating their views and the benefits to be accrued from involving them more directly in their children's education (Family Focus, 1983). Academics and formal representatives of the 'rights' movement have also expressed

concern about the manner in which children with special needs are assessed and educated (Tomlinson, 1983; Newell, 1985).

- (b) *Parental Involvement.* More attention has now been given to the direct involvement of parents in the education of children with special needs (Wolfendale, 1983). It is recognized that they have a major role to play and should be viewed as partners in their children's education, rather than passive spectators.
- (c) *Falling rolls.* The fall of the birthrate has led to reduced pupil numbers, which can be viewed as either an opportunity to improve provision or as an opportunity to reduce expenditure (Coventry Education Committee, 1984).
- (d) *Educational Considerations.* In England and Wales a major government report (D.E.S., 1978) made a number of recommendations about the education of children with special needs. The report was based on a review of both the national and international research carried out into the integration of children with special needs into ordinary schools (Cave and Maddison, 1978). The report stimulated much debate as it introduced the following assumptions about the education of children:
  - Any child, whatever his overall attainment level, may experience a difficulty at some stage in his school life.
  - As the handicapped and non handicapped do not present two discrete groups special help and support must be available to all pupils when necessary.
  - Educational difficulties result from an interaction between what the child brings to the situation and the programme provided by the school. The focus of concern therefore needs to move from within child variables to examining the interaction of variables.
  - Because it is now recognized that up to twenty per cent of all children have special needs at some stage in their school careers all teachers have to be teachers of children with special needs.
  - Support must be available to staff in mainstream schools to help them fulfill their responsibilities.
- (e) *Legislation.* Some of the new concepts about special education have been embodied in an Act of Parliament, known as the 1981 Education Act (D.E.S., 1981). This has certain similarities to Public Law 94-142 in

the United States in as much as its intention is to facilitate a full examination of the educational needs of handicapped children, and where possible make educational provision for them in ordinary schools. However, such placement must be compatible with

- the child receiving the special educational provision that s/he requires;
- the provision of efficient education for the children with whom s/he will be educated; and
- the efficient use of resources.

In addition, the 1981 Education Act requires School Governors to use their best endeavours to see that pupils' special educational needs are met; that these special needs are known to all teachers who are likely to deal with them; and that all teachers in a school are aware of the importance of identifying and providing for all children with special educational needs.

### ***Local Considerations***

In 1982 the Special Needs Action Programme (SNAP) was launched in Coventry Local Authority to assist all schools to fulfil their responsibilities with respect to the education of children with special needs. Before providing an account of the implementation of SNAP in Coventry, and describing how it has developed subsequent to the original launch of the programme (Muncey and Ainscow, 1983; Ainscow and Muncey, 1983), it is necessary to consider certain aspects of the local context in which it has been formulated.

Coventry is a geographically small area with a dense population with diverse needs. There is a sizeable ethnic minority composed primarily of Asians. Special education provision within the City has been generous by British standards and an impressive range of facilities and services exist. For a school population of just under fifty thousand, there are currently fifteen special schools plus a number of special units. There is also a range of support services which include educational psychologists, advisers, community education and minority group support services. Furthermore, there is a history of high quality in-service education being offered to teachers, many of whom have advanced qualifications. However, the plethora of special facilities and support agencies has tended to give rise to the view that children with special needs can be better catered for in some form of provision segregated from mainstream schools.



The changes in thinking about special education, described above, have therefore presented somewhat of a challenge. It is to this challenge that the Special Needs Action Programme (SNAP) has addressed itself.

### ***The Special Needs Action Programme***

SNAP has grown out of a desire to utilize the heavy resource investment and expertise in special education facilities to support the large group of pupils with special needs in ordinary schools. It offers to teachers a co-ordinated programme to help them deal with some of the day to day issues they encounter in the classroom. Specifically, the aims of the programme are:

- (i) to encourage Head Teachers of ordinary schools to develop procedures for the identification of pupils with special needs;
- (ii) to assist teachers in ordinary schools to provide an appropriate curriculum for such pupils; and
- (iii) to co-ordinate the work of the various special education support services and facilities in supporting teachers in ordinary schools.

As special needs must be defined within a context it follows that each school must develop policies and practices which are compatible with its situation and ways of working. In addition it must be recognized that schools already have certain procedures for supporting children with special needs; many of these procedures are quite appropriate and do not necessarily warrant being supplanted by new methods. It is therefore important that SNAP does not attempt to impose one model for achieving the aims set out above. Rather SNAP disseminates examples of good practice which schools can use as a vehicle for reviewing, and where necessary, extending existing procedures.

The aims, as stated, are far reaching so that their achievement will take a period of years. With this in mind, SNAP concentrates on four main responses:

1. *Information* is provided about the resources and services available within the Authority. This information is presented at meetings, in booklets and via audio visual presentations.
2. *Courses* are presented initially to representatives from each school at the Teachers' Centre and then as part of school-based, staff development programmes.
3. *Materials* are disseminated which have been used and evaluated by experienced special educational teachers. Some materials form an

integral part of the courses while others provide necessary support, and may be derived from commercial products where appropriate.

4. *Advice and help* is given by members of the various support services, including staff from special schools.

The first two years of the project were concentrated mainly in primary schools, which cater for children from pre-school to 11 years. More recently, SNAP has begun to have an impact on secondary schools, with their population of pupils from 11 to 18 years.

The format of SNAP in these two sectors of education will now be looked at in more detail.

### ***SNAP in Primary Schools***

Between the summer of 1982 and December 1984, all Coventry primary schools were introduced to the programme. Each school was asked to nominate one relatively senior member of staff to act as co-ordinator for special needs. They are committed teachers who are fully involved in the school, and have the qualities necessary for helping colleagues to learn new approaches. In some case Heads or Deputy Heads have chosen to take personal responsibility for the task. It is the co-ordinator's role to:

1. make colleagues in the school aware of their responsibilities to pupils with special needs;
2. co-ordinate the development of school-based strategies for the identification, support and review of these pupils;
3. assist teachers in the school in the development of appropriate programmes for these pupils;
4. provide information for colleagues about special education resources and services available in the local authority.

As can be seen, the emphasis is on working through the system of the school to provide a whole school response to children's special needs.

To assist co-ordinators in developing their roles and, in so doing, help their colleagues deal with children's special needs, a series of modular in-service courses have been devised. The modules currently being used in Coventry primary schools are shown in Figure 1, and described below:

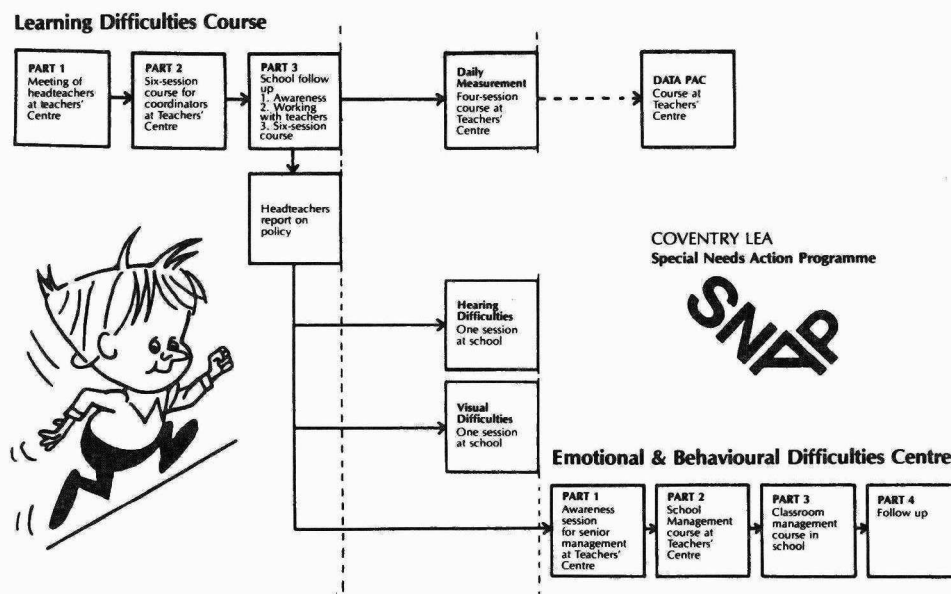


Figure 1: SNAP in Primary Schools

### Teaching Children with Learning Difficulties

Based on a workshop guide called 'Small Steps' this six-session course teaches procedures for designing individual programmes for children with learning difficulties in the primary school. The course materials also include a tutors' guide, books of child studies, various record forms, two tape-slide presentations and six video programmes.

### Daily Measurement

This four-session course teaches procedures for monitoring the progress of children with learning difficulties on a daily basis. There is a workshop guide called "Daily Measurement", a tutors' manual, a book of examples and a tape/slide presentation.

### Data Pac

This is a comprehensive criterion referenced test which was developed at Birmingham University by a group of educational psychologists. At present it is only being used in selected schools under the guidance of an educational

psychologist. It is hoped that eventually it will be disseminated more widely to schools that have successfully completed the course on Daily Measurement.

### ***Helping Hearing Impaired Children***

This course consists of tutors' guide and a tape/slide presentation. It presents information on the identification and support of children with hearing difficulties in ordinary schools.

### ***Helping Children with Impaired Vision***

This course deals with the identification and support of children with visual difficulties in the ordinary school. It consists of a tutors' guide and a two-part tape/slide presentation.

### ***Problem Behaviour in Primary Schools***

This course is in two parts. Part one examines issues of school management, organization and support, whilst part two is concerned with classroom management. There are two workshop guides, a tutors' manual, three tape/slide presentations and a video.

In addition, there have been a number of other developments to assist the development of SNAP in primary schools. These include:

- a range of publications have been produced to assist co-ordinators, e.g. "SNAP and Ethnic Minority Children", "Childhood Illness and Disability: Notes for Teachers", and various classroom checklists.
- an occasional newspaper, "SNAP News", keeps school informed of new developments in the programme.
- regular meetings of co-ordinators are held to discuss problems and share ideas. Some of these are held centrally; others are arranged on an area basis, often in conjunction with neighbourhood secondary school staff.
- members of the various advisory and support services provide a programme of visits to support the follow-up phase of the various courses.
- the local authority arranges for schools to have short periods of additional staffing to free co-ordinators to carry out development work.

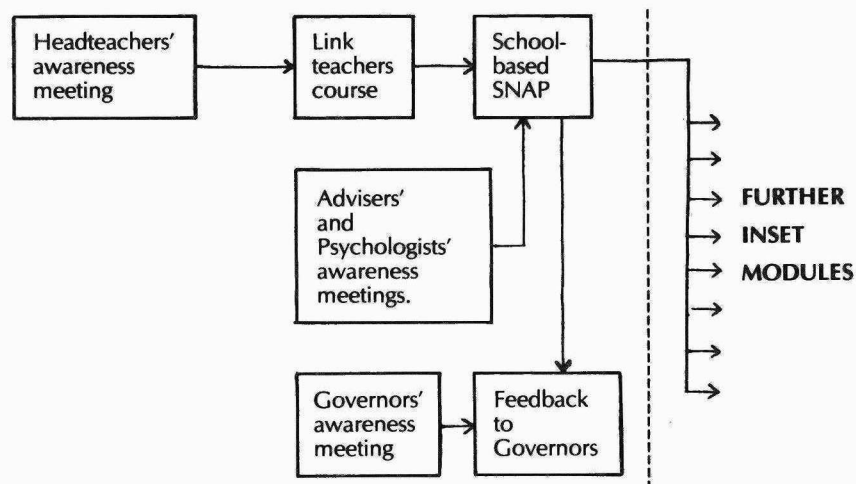
### ***SNAP in Secondary Schools***

At the beginning of 1985 the first phase of the development work on secondary SNAP was completed. A main module entitled "Special Needs in the Secondary School" has been produced, together with a series of optional mini courses. The overall aims of the programme are to:

1. develop positive attitudes towards the idea of meeting pupils' special needs in the secondary school;
2. assist schools in reviewing their policies and practices with regard to special needs;
3. provide information about available support services and the implications of the 1981 Education Act.

The main course consists of six units of written study material, supported by audio-visual inputs. These are used as a basis for a course at the teachers' centre for pairs of senior members of staff nominated by secondary schools. They then act as link teachers. As such, they are expected to devise and implement a school-based response using relevant parts of the course material and involving all members of staff. Local Authority support is provided for these activities.

The overall plan of the "Special Needs in Secondary School" initiative is summarized in Figure 2.



**Figure 2:** SNAP in Secondary Schools

In addition to the two main elements (i.e. the teachers' centre course for link teachers and the school-based activities for all staff) there are awareness sessions for Headteachers, advisers, educational psychologists and governors, all of whom have important roles to play in the initiative. It is assumed that Head teachers will eventually report to their Governors on the implications of the course.

The anticipated outcomes for individual schools are that:

- The whole staff should be aware of the 1981 Education Act and its implications.
- The school should have reviewed its arrangements for meeting special needs.
- Individual departments should have reviewed their curriculum, teaching methods and resources to question their appropriateness for all pupils.
- All teachers should, having reviewed present practice, reached the stage when they have ideas about what they need to do next.
- All staff should be aware of what help and support is available.

Associated with the course is the "Special Needs Review Schedule", which can be used by each school to consider its policies and practices with regard to special needs. It is anticipated that the course activities will lead to the identification of further in-service needs which might be met either by other LEA courses or specific school-based responses. The course materials comprise six units, one for each session of the full course that takes place in the teachers' centre. Each unit has three sections, as follows:

(i) *Study Material*

This is to be read by participants *before* the course session. It provides relevant theoretical information which should be useful during the course activities and discussions.

(ii) *Tutors' Notes*

This includes a timetable for the course session and a series of sheets explaining how each of the practical activities should be conducted. Suggestions are also made as to how the activity might be adapted for use in schools.

(iii) *Resources*

These are the materials needed in order to conduct the course activities. They can be photocopied for use in schools.

In addition to the six units, supplementary materials are provided in a series of appendices.

Having taken part in the course, link teachers are expected to devise and mount some form of SNAP initiative for all their colleagues. The nature of this will vary from school to school, and part of the course at the teachers' centre is devoted to its planning. It is important to note, however, that the material is deliberately presented in a loose-leaf form to facilitate its flexible use. It is assumed that schools will only use those sections which are relevant to their needs.

During the teachers' centre course all the materials are considered and participants take part in each of the activities. As the course progresses, consideration is given as to which of the materials might be used as part of school-based SNAP and, indeed, how they might be used.

The six units cover the following topics:

UNIT 1. Special Education Needs – Some Key Issues

Changing ideas about children with special needs.

UNIT 2. Curriculum

Making the curriculum relevant and accessible for all pupils.

UNIT 3. School Organization

Advantages and disadvantages of different forms of school organization.

UNIT 4. Classroom Organization and Practice

Classroom factors which facilitate learning.

UNIT 5. Attitudes and Relationships

Key relationships which influence pupil progress.

UNIT 6. Support and Help

Making the best use of support personnel. Designing a school-based staff development course on special needs.



**Evaluation**

Whilst SNAP is still in its infancy in secondary schools, it is now well established in many Coventry primary schools. Various evaluations that are being carried out have begun to indicate aspects of the initiative that have been successful and, of course, point to areas of significant difficulty.

There are a number of evaluation strands associated with the project. They are:

1. At the formative stage of each in-service module, the materials are carefully field-tested using a group of schools that are representative in terms of size, organization and location.
2. A long-term evaluation is being conducted of the effects of SNAP in eleven primary schools. This DES-funded project began at the University of Leicester (Brooks 1983) and is being continued by a research team at the National Foundation for Education Research.
3. A further group of schools have been followed up by a research team from the "Screening and Special Education Provision in Schools" project at the University of London Institute of Education.
4. In addition, a number of teachers studying for advanced qualifications have carried out intensive case study type evaluations in Coventry primary schools.

An analysis of the evidence available certainly suggests, however, that SNAP is having a significant impact in schools, and that the changes brought about are enduring. Some of the features which have facilitated the impact of SNAP are discussed below. It is suggested that such features might profitably be considered by others embarking on in-service programmes.

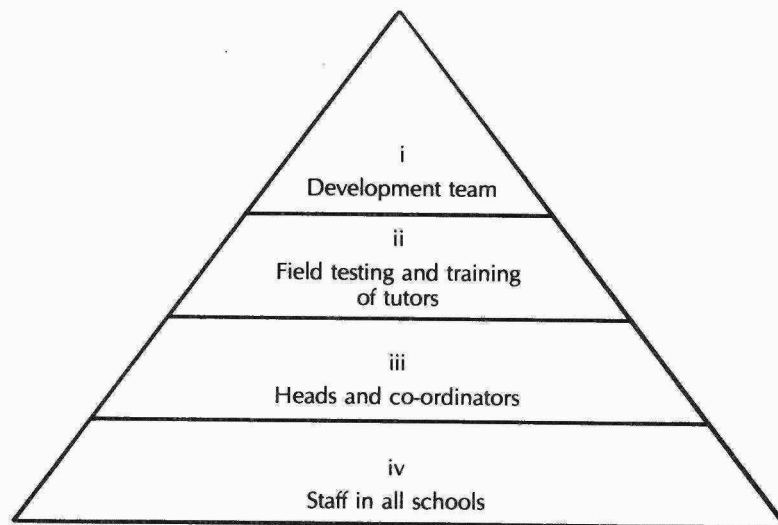
**Features**

1. *Early identification.* Many in-service initiatives have commenced with formal screening of children (e.g. Gray and Reeve, 1978; Wolfendale, 1976). However, there are significant problems in such an approach (Satz and Fletcher, 1979). Rather than imposing formal screening tests SNAP encourages class teachers to use their own skills in identification, and to relate identification and diagnosis directly to the curriculum.
2. *Involvement of all teachers.* The importance of all teachers taking responsibility for all children in their class is stressed (Dessent, 1983), so

that the emphasis is on movement away from the notion of the "expert", to increasing the skills of all teachers. Thus the theme running throughout SNAP is that "all teachers are teachers of children with special needs." The involvement of all staff in a school also facilitates a commitment to implement any changes that are agreed (Cruikshank et al., 1979).

3. *Practical content.* When teachers embark on an in-service programme they are generally seeking ideas which they can translate directly into classroom practice. Programmes which are practically, rather than theoretically, orientated are therefore likely to lead directly to changes within the classroom (Powers, 1983). The modules therefore present practical ideas that can be used in the classroom, providing what Smith and Siantz (1978) refer to as "innovation in the concrete". They also attempt to provide the teacher with maximum early success, as recommended by Mann (1976). This seems to be much appreciated by participants who suggest that so many in-service experiences provide theory without any attention to practical implications.
4. *Active learning.* The emphasis on active learning approaches to problem-solving, as opposed to the traditional didactic teaching style of so much in-service training, encourages participation and seems to help overcome fear of change (Houston and Freiberg, 1979).
5. *Competency based.* All of the modules are competency based so that clear statements are made concerning the skills that will be acquired at each point in the courses. Such statements form the basis for planning and evaluation (Blackhurst, 1977).
6. *Multi media modules.* Each module is self-contained and multi media, consisting of manuals, materials, tape/slide presentations, and where appropriate, videos. This facilitates their use as part of school based staff development programmes (Rude, 1978).
7. *Tutored by practising teachers.* The fact that all courses are led by practising teachers enhances their credibility, emphasizing the practical nature of the approaches advocated (Mann, 1976).
8. *Staff support.* In attempting to help all teachers it is recognized that considerable demands are being made of schools. It is therefore important that support is given to staff within schools (Moore and Fine, 1978).

9. *Course development and dissemination.* In order to involve and influence a maximum number of personnel, a pyramid training model is used as a basis for the design and dissemination of each SNAP module. This has the advantage that participants at each level have the opportunity to overlearn ideas and skills they have recently acquired through the experience of acting as tutors to others (Jones et al., 1977). Figure 3 illustrates the four levels of development and dissemination involved in all the SNAP courses in Coventry.



**Figure 3**

It works as follows:

- (i) *Development Team*  
Groups of colleagues with appropriate expertise are brought together to formulate and develop course materials.
- (ii) *Field-testing and Training of Tutors*  
At an appropriate stage, the development team field-test their materials with selected special education colleagues (including members of the various support services), some of whom will eventually be used as course tutors.

(iii) *Heads and Co-ordinators*

Once the course materials have been finalized, they are disseminated through courses held at the teachers' centre for heads and co-ordinators for special needs.

(iv) *Staff in all Schools*

Finally, heads and co-ordinators use the course materials as part of school-based staff development initiatives with a view to reviewing existing policies and arrangements.

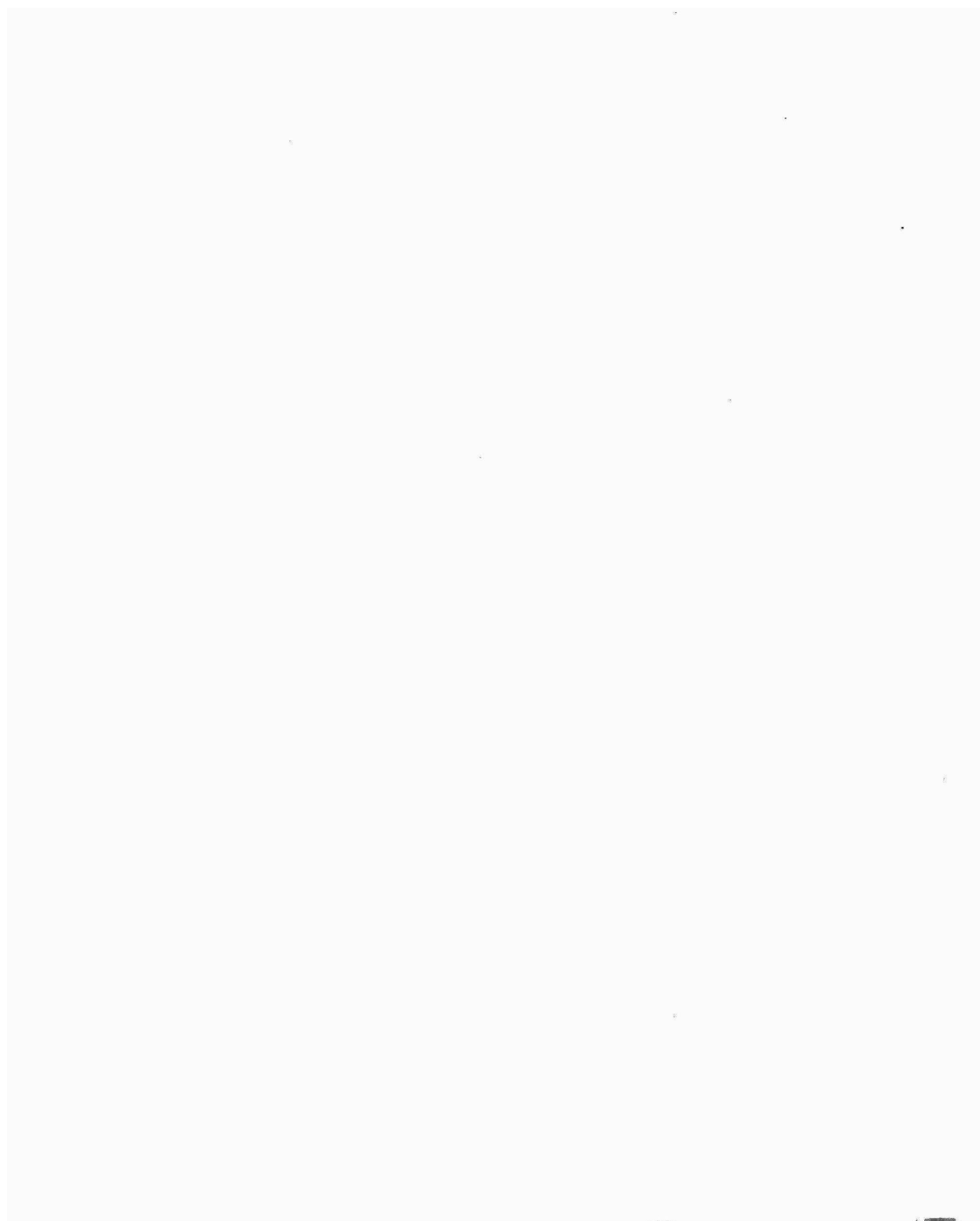
### **Conclusion**

As SNAP develops it is encouraging to see the varied ways in which schools are developing a whole school response to the education of children with special needs. The success of the approach within Coventry has led to SNAP being used extensively by colleagues in other education authorities in Britain, and within higher education establishments. It is hoped that in turn this article may go some way to sharing our ideas and approaches with our transatlantic colleagues.

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## **SPECIAL EDUCATION IN MALAYSIA: A CRITIQUE**

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*Special education was introduced into Malaysia in 1926 and has made steady progress since then. There are now over 4,220 exceptional students enrolled in special education programmes for four categories of children — the visually handicapped, the hearing impaired, the mentally retarded and the physically handicapped (including the cerebral palsied). Issues discussed include the nature of special needs (such as special education teachers, early diagnosis, avoidance of negative labelling or mislabelling, a modified curriculum, an individualized education programme, feeling of success, self-competition versus peer-competition, a multi-disciplinary approach, special apparatus and equipment and parental counseling) and the extent to which such needs are being met. A few suggestions for improving the position are also made.*

### **1. Introduction**

In Malaysia, formal special education may be said to have its origin in 1926. The target population comprising the visually handicapped, the hearing impaired, the mentally retarded, the physically handicapped and such like children, are still often termed 'handicapped'.

The term 'exceptional' rather than 'handicapped' should be used for the following reasons:



- (i) the term 'handicapped' by itself is misleading as it seems to imply that the person who is blind or deaf or orthopaedic is 'handicapped' in all respects. In the vast majority of cases, a person who is blind is handicapped only visually, a person who is deaf is handicapped only auditorily and a person who is orthopaedic is only handicapped physically.
- (ii) persons who are blind, deaf or orthopaedic often have special talents or gifts and so should not be labelled 'handicapped'; for example, a university student who is blind may have an extraordinary memory or be very eloquent, a person who is deaf may have exceptional talents as an artist or craftsman while an orthopaedic person who uses a wheelchair can be a senior company executive.
- (iii) in certain circumstances the handicapped blind, deaf or mentally retarded have decided advantages over so-called 'normal' or non-handicapped individuals; for example, the blind child can study late into the midnight hours through tactual braille with the lights off without disturbing his sighted brother who shares the same bedroom with him; some people who are deaf work comfortably because they are not bothered by the hum of conversations; a person who is mentally retarded may be happy working at an assembly line because he generally loves routine and repetitive work which is considered boring by a non-mentally handicapped worker.
- (iv) when the term 'handicapped' is used, it should be qualified; for example, one speaks of a child who is visually or hearing handicapped or one who is physically handicapped.
- (v) the term 'handicapped' by itself carries negative connotations. With education and rehabilitation, a blind can overcome his visual handicap by using non-visual media such as tactual braille, audio tapes and three-dimensional models or embossed materials. Similarly, a deaf child can solve his hearing problem by using lip-reading, finger-spelling, sign language or total communication. A mentally handicapped factory worker no longer deserves the label 'handicapped' as his assembly line work may not require complex or abstract thinking process.

Other alternative and more appropriate terms to use to describe blind, deaf and such like children are 'special' or 'children with special educational needs'.

Thus, the so-called 'slow learner' is not generally 'handicapped' in all aspects of learning. He may be handicapped in mastering abstract language skills but may excel in art or in the sports field. The suggested two alternative terms are also more appropriate when applied to the intellectually superior or mentally gifted or talented children who need special education treatment if they are to develop to their maximum potential.

## **2. *Special Needs of Exceptional Children***

When discussing the special needs of exceptional children one must be cautioned against over-simplification and over-generalization. When speaking of exceptional or special children, or of the blind, the deaf and the slow-learners, there is a tendency to treat them as separate, homogeneous and stereotyped groups with almost similar characteristics; one needs to be reminded that no two blind children or two gifted children are alike and so one cannot speak of the same special education treatment for all children within a disability group. The special needs of exceptional children may be categorized as follows:

- special education teachers,
- early diagnosis,
- avoidance of negative labelling or mislabelling,
- a modified curriculum,
- an individualized education programme and smaller class size,
- feelings of success,
- emphasis on self-competition and not peer competition,
- a multi-disciplinary approach,
- special apparatus and equipment, and
- parental counselling.

The nature of special needs, the extent to which such needs are being met and suggestions on improving the situations are discussed in subsequent paragraphs.

## **3. *Special Education Teachers***

Teaching special children and youth is a specialized field, which includes the use of special teaching-learning media such as braille for the blind, Total Communication (including lip reading, signing, finger-spelling and speech) for the deaf and the Bliss Symbol Communication System (Bailey & Jenkinson, 1982) for children with speech-cum-motor deficiency. Prior to 1962, special educa-

tion teachers were trained overseas but the Malaysian Ministry of Education now has full-time one year training courses at the Specialist Teachers Training Institute (STTI), Kuala Lumpur for trained teachers with at least 5 years of experience teaching regular children. These courses offer specialization in three areas (Chua, 1977):

- (i) education of the visually handicapped (since 1962),
- (ii) education of the hearing handicapped (since 1963), and
- (iii) education of slow learners (since 1977).

Since the 1970's the Faculty of Education, University of Malaya has also conducted elective courses on special and remedial education at the M.Ed. level. The Ministry of Education has also introduced exposure courses on teaching slow learners in its pre-service basic three-year teacher training programme and through in-service vacation courses.

A point of concern is that there has been a high drop-out rate among trained special education teachers. Of the 157 trained teachers of the visually handicapped, only 58 (36.9%) have remained in service (Ministry of Education, 1983). For the deaf, out of 201 trained teachers, 164 (81.6%) are still in active service (Ministry of Education, 1983). Although over 1,970 teachers have been trained to teach slow learners in the one-year STTI course and through vacation and weekend exposure courses, not all of these teachers are engaged in remedial work. A fairly large number of special education teachers have left teaching exceptional children because they have been promoted to higher positions, such as principals of regular schools, have gone on to further studies, or have returned to the teaching of regular children. This is a serious waste of trained manpower. In order to retain such scarce manpower and to attract better qualified teachers into the field of special education, an incentive, non-pensionable allowance (equivalent to one or two years' annual increment) should be paid to serving special education teachers for the following reasons:

- (i) in recognition of their additional professional training equivalent to 9-12 months of full-time study in special education,
- (ii) teaching exceptional children demands greater industry, resourcefulness, creativity, good relationship with children, effective planning and cooperation with school and staff (Bourgeault, 1970),
- (iii) the number of promotion posts as heads of special schools is very limited,

- (iv) many developed and developing countries do recognize the special position of such personnel by paying an incentive allowance or placing them on a higher salary scale.

The 1,970 remedial education teachers who have been trained so far are unable to meet the needs of primary school slow learners estimated at 10% (Chua, 1978) or 214,500 (Ministry of France, 1985) which translates to 120 slow learners for each remedial teacher. However the number of such teachers is being gradually increased by the Ministry of Education through its STTI one year course and in-service courses. Teacher trainees in all the Ministry's basic teacher training programmes have recently been exposed to some aspects of remedial education. More teachers for the hearing impaired are also needed.

There are three other types of exceptional children in need of special education teachers — the mentally retarded, cerebral palsied and the mentally gifted children, cited in order of priority. Although over a thousand mentally retarded are in special government and private schools or centres (Chua, 1983), only three teachers have had at least a year's professional training in teaching the mentally handicapped. However, some of the other teachers have attended short weekend training courses. The current teacher preparation curriculum on teaching slow learners at STTI can be modified to include aspects of teaching mentally retarded and cerebral palsied children, thus meeting the crucial need for professionally trained teaching staff. In many countries, including the Philippines, facilities are available for full-time training of teachers for the mentally gifted or talented. In the case of Malaysia, short in-service courses should be provided to arm teachers with the know-how to challenge bright and creative children.

In terms of administrative programmes for special children, four types have not been utilized in Malaysia: special classes for mentally retarded children in regular schools and more residential facilities for children from rural areas since there is a waiting list of 630 children (Chua, 1983); itinerant programmes serving two or more schools where the hearing-impaired have been integrated into the regular stream; special express classes for the mentally gifted in regular schools and enrichment programmes for such children in special and/or regular classes; and chronically-ill children who have to stay in hospitals for long periods of treatment should be educated in special classes set up in the hospitals.

#### **4. Early Diagnosis and Education**

In the vast majority of cases, blind, deaf, mentally retarded and other special children in Malaysia are admitted into special schools or classes only at the age of 6 years in line with non-disabled children. This late age admission for exceptional children is most unsatisfactory for the following reasons:

- (i) learning problems of exceptional children become more difficult to remediate because of what has been termed 'cumulative deficiency' (Awang Had, 1979),
- (ii) on the effects of early intervention in social-cultural aspects of mental retardation, studies by Kirk (1985) have suggested that 'intervention at age two is more effective than at four, and that intervention at age four is more effective than at age six' (p.225),
- (iii) studies on specific categories of exceptional children have also indicated the value of early diagnosis and education before the age of six years. Magary and Freehill (1972) maintain that the period between age three and seven is critical for the mentally gifted; for the blind child, the early months of the child's life and the years of the preschool period are of primary importance as they are 'critical' and determine the course of his later development (Norris et al., 1957); for the hearing-impaired, Watson (1961) has quoted various studies to show 'clearly that children who are supplied with hearing aids at an early age learn to make very considerable use of their hearing capacity'. Mindess and Keliher (1967) have specifically cited important implications for early screening and prevention of physical, emotional and behavioral difficulties; for example, lazy eye blindness can be helped if its is detected before eyes are fully developed at age six years; De Hirsch et al. (1966) have demonstrated that valid predictions of reading, spelling and writing achievement can be made by evaluating children's perceptual motor and language behaviour in the early years, and that many intelligent but educationally disabled children would not have required help had their difficulties been recognized early. Glueck (1966) claims that one can even predict delinquency at the age of five years.

The importance of early identification and education of exceptional children has been recognized by the Ministry of Education through the Cabinet Com-

mittee Report Resolution No.171 which recommends that deaf children be allowed to begin schooling before the age of six years (Malaysia, 1979). However, this has been implemented only partially although formal education for the deaf in Malaysia began more than 29 years ago (Chua, 1971).

### **5. Avoidance of Negative Labelling or Mislabelling**

Special education facilities in Malaysia are still associated with negative labelling. The blind, the deaf, the mentally retarded and other such children are still referred to as 'handicapped' by both government and private organizations. Many Malaysians still refer to the hearing-impaired as 'deaf and dumb' in spite of the fact that the deaf are being taught to speak in addition to using gestures (sign language) and finger spelling (manual alphabet). Neither are parents or general education teachers more enlightened by the use of such terms as 'autistic' or 'Down's Syndrome'. A label has often been wrongly used as a cause of a learning problem. It is more helpful if the special education teacher can describe some of the specific difficulties experienced by these children, including specific steps in ameliorating such a condition.

An appeal is made to all personnel such as parents, special education and general education teachers, social workers and doctors dealing with special or exceptional children to avoid mislabelling or using negative terms and opt for positive or neutral terms. We speak of the partially sighted and not the partially blind, the partially hearing and not the partially deaf, the special class not the class for slow learners.

### **6. Modified Curriculum**

The school curriculum for special children has been modified. The blind child learns to read and write braille, uses more auditory and tactual learning materials and engages in an additional 'subject' — orientation and mobility. The deaf child learns, in addition to the regular curriculum, lip-reading, speech, signing, finger spelling (Total Communication) and has special sessions for auditory training. The special schools/centres for mentally retarded concentrate on a more multisensory approach and require more programmed instructional materials and behaviour modification principles. While much more has been done for the blind, including special provisions in public examinations, relatively little has been done to review the curriculum including special examinations for the deaf (Hashim, 1983). For the mentally retarded and spastic, there are no clear curriculum guidelines and each special school/centre has to devise



its own curriculum based at times on trial and error. However, Sebastian (1985) has developed a suggested curriculum for use in schools for the mentally handicapped in Malaysia. There has been a tendency for the curriculum to be too academically-oriented especially at the secondary and tertiary levels (Chua, 1983).

Special committees should be set up under the chairmanship of the relevant Ministry to review existing curricular especially for the education of the following categories of exceptional children:

- (i) the visually handicapped,
- (ii) the hearing impaired,
- (iii) the mentally retarded,
- (iv) the physically handicapped including the cerebral palsied,
- (v) children with special education needs (or 'slow learners'),
- (vi) children who are intellectually superior or mentally gifted or talented (Chua, 1982).

### **7. Individualized Education Programme (IEP) and Smaller Class Size**

Basic to special education is the need to recognize individual differences. This does not mean that there must always be a one teacher to one special child although in the case of a multi-handicapped child such as a spastic child who has severe mental retardation, poor gross motor functioning, severe visual and auditory impairment, a one-to-one relationship may be necessary. Our current class size of 40-50 children (some of whom have special learning problems) is too large for teachers to handle effectively. While some research studies have indicated that class size does not adversely affect the learning of factual material, it is professionally unsound to emphasize this type of learning. Keliher (1967) has cited research evidence to indicate that 'small classes produced more educational creativity . . . children more likely to . . . receive individual attention and there was more variety in instructional methods . . . teachers more likely to observe children, keep records of children behavior and conduct good parent conference . . .' (p.20). The doctoral dissertation by Richmond (1955) has indicated that small classes of 25 have led to increased face-to-face relationships between pupils and teachers, opportunities for pupils to choose learning materials, knowledge of teachers concerning their pupils' individual abilities, knowledge by teachers of the potentiality of their pupils, teacher attention to provide informal pupil guidance, teacher awareness in observing covert pupil behaviour suggesting emotional instability, work with



the bright and backward child and attention to grouping and greater flexibility of group work.

The Ministry of Education should be congratulated for recognizing the importance of small classes and has approved class enrolment of 10-12 pupils in special classes for the blind, the deaf, the mentally retarded and the cerebral palsied. However, a word of caution is in order here. It is sheer waste of effort and money if a teacher in a class of 25 or 30 is doing precisely what he has been doing with 50 pupils.

Currently special education teachers in Malaysia use their own initiative and discretion in preparing lesson plans for their special children. A case can be made for adopting the IEP concept from the USA. In an individual education plan (IEP) the following statements have to be made by the special education teacher for each particular student:

- (i) the student's present levels of educational performance;
- (ii) annual goals, including short-term instructional objectives;
- (iii) specific special education and related services to be provided to the student and (in the case of an integrated programme student) the extent to which he will be able to participate in a regular educational programme;
- (iv) projected dates for initiation and duration of services;
- (v) appropriate objective criteria and evaluation procedures and schedules for determination, on at least an annual basis, whether the short-term instructional objectives are being achieved (Hayes & Higgings, 1978).

The advantages of an IEP include the following:

- (i) instructional objectives and strategies are specified;
- (ii) each student can progress at his own pace;
- (iii) his progress is continuously monitored;
- (iv) parent and other members of the multidisciplinary team can easily refer to the IEP and may even suggest changes to the programme.

It is, therefore, suggested that the Ministry of Education seriously consider the implementation of the IEP concept and the reduction of class size. In fact, to partially offset the cost of implementing smaller classes at the primary level, existing approved class sizes of 50 at the primary school level and 35 at the

Form 6 Arts level can be reversed, since pre-university students are more mature and relatively more capable of independent study.

### **8. *Feelings of Success***

Whether exceptional children are studying in residential or day special schools or in special classes in regular schools or fully integrated in the regular class, their fundamental needs — the need for feelings of success, of worthiness and of value — have to be met. Too often children with learning problems have returned home to face the wrath of parents with report books dotted with red marks.

General or special education teachers have the responsibility of utilizing appropriate evaluative procedures, sequentially arranged and geared to the developmental level of the pupils so that children with learning problems do not feel they are failures throughout their school life, more importantly that failure in school does not necessarily mean failure in their working or adult life, as the skills required may be very different. Constant encouragement is necessary to guide the child through small sequential steps so that progress, though slow, is taking place and the exceptional child more so than the so-called normal child will appreciate the truth of the statement, 'Nothing succeeds like success'.

### **9. *Self-Competition Versus Peer Competition***

The present school system for exceptional children in special schools or in special classes in regular schools or in mainstreaming emphasizes peer competition through monthly or annual tests or examinations. This occurs when the ranked positions in a particular class or form level are highlighted. This is well and good for those in the top 5 or 10 percent but it brings about adverse psychological effects on children who are always at the bottom of the class and it sets up the problem of the self-fulfilling prophecy. It is good to note that some schools, though too few, not only reward those who excel in their studies but also those who have made the most individual progress and others who show talent in other non-academic activities such as sport and the performing arts. The emphasis should be on self-competition through criterion-reference tests rather than peer competition through norm-reference tests.

### **10. *A Multidisciplinary Approach***

An interdisciplinary or multidisciplinary approach to educating special

children is necessary as the needs of each child are so varied. Among the specialist staff required are the following:

- (i) the special education teacher for special education management;
- (ii) the general class teacher for individualized curriculum;
- (iii) the paediatric neurologist for medical diagnosis and treatment;
- (iv) the educational psychologist for psychological testing and behaviour modification;
- (v) the child psychologist for play therapy;
- (vi) the child psychiatrist for child psychotherapy;
- (vii) the speech therapist for speech therapy;
- (viii) the occupational therapist for perceptual and other training;
- (ix) the physiotherapist for psychomotor training;
- (x) the optometrist for visual training;
- (xi) the nutritionist for vitamin therapy;
- (xii) the nurse for health care;
- (xiii) the social worker for home therapy.

Malaysia is particularly short of educational psychologists, child psychologists, child psychiatrists and speech therapists. Malaysia has its own training programme for physiotherapists and occupational therapists. There is an urgent need to train speech therapists for the hundreds of children suffering from speech problems amongst the hearing handicapped and the large number of so-called slow learners or children with general or specific learning problems.

### **11. *Special Apparatus and Equipment***

Associated with special education is the increasing contribution from technology in the form of new and sophisticated teaching-learning electronic machines and electronic hearing aids and speech trainers. For the visually handicapped, some technological development includes the Kurzweil Reading Machine, the Optacon, Speech Compressors, Talking Calculators, the Sonic-guide, the Laser Cane, the Versa Braille, and Talking Computers (Chua, 1983). The Ministry of Education should be congratulated for having acquired one of the most modern stereo copiers which can reproduce embossed maps and diagrams directly from two dimensional inkprint or plain writing copies. A number of new electronic aids for the hearing handicapped are in the market, including the Canon Communicator, the Visible Speech Training System and AM-COM Telephone/Typewriter (Chua, 1978).

Rion of Japan has recently produced an electro-palatograph in which certain sounds produced by the deaf child are translated into visual images to facilitate speech training. The relative inadequacy of special equipment in integrated programmes for the visually handicapped in regular secondary schools has been highlighted by Filmer (1982). The need for maintenance and regular updating of electronic group-hearing equipment and individual hearing aids in special classes for the hearing handicapped has been identified by Hashim (1983) in a national seminar on education of the deaf.

There is need to make a systematic study of existing equipment and aids for all categories of exceptional children with the following aims in mind:

- (i) to update existing equipment;
- (ii) to supplement existing equipment;
- (iii) to have periodic maintenance checks to ensure maximum functioning of such equipment.

## **12. Parental Counselling**

On the whole there is no large-scale organized counselling of parents of exceptional children in spite of the importance of early childhood intervention. Problems and suggested solutions with regard to counselling of parents of visually-handicapped and hearing-impaired children have been identified by Chua (1979, 1983/84). The main objectives of parental counselling are as follows:

- (i) to give normal and professional support to parents;
- (ii) to assist parents in coping with such feelings as anger, rejection, overprotectiveness, guilt, shame and/or anxiety;
- (iii) to guide parents in developing in their preschool children basic skills of daily living and language development;
- (iv) to help parents make decisions on such matters as medical treatment and school placement;
- (v) to assist parents in providing vocational guidance to their children.

More efforts should be made to counsel parents of exceptional children. In isolated rural areas, printed informative materials should be made available. More use should be made of television, radio and the newspaper to enlighten and guide parents.

### 13. Enrolment in Special Schools/Centres

Numbers enrolled in special education schools or centres seem to suggest that large numbers of exceptional children remain unidentified and unlocated. Based on four categories of exceptional children the visually handicapped, the hearing impaired, the mentally retarded and the physically handicapped — as shown in Table 1, about 3.41 percent of the Malaysian population aged 6-18 years of 168,708 may be said to be handicapped.

**Table 1**

Possible Prevalence Rates and Estimated  
Number of School-Age Handicapped Persons  
Aged 6-18 years in Malaysia 1984

Estimated Total Population in 1984: 15,270,000 <sup>1</sup>		
Percentage of Total Population Aged 6-18 Years: 32.4 <sup>2</sup>		
Estimated Total Population Aged 6-18 Years: 4,947,480		
Type of Handicap	Prevalence <sup>3</sup> Rate %	Estimated Population
Visually Handicapped	0.04	1,979
Hearing Impaired	0.46	22,758
Mentally Retarded	1.46	72,233
Physically Handicapped (including cerebral palsy cases)	1.45	71,738
TOTAL	3.41	168,708

<sup>1</sup> Malaysia, Ministry of Finance, *Economic Report 1985/86*. Kuala Lumpur, National Printing Department, 1985, p.vi.

<sup>2</sup> Collated from *General Report of the Population Census 1980: Vol. 2*. Kuala Lumpur, Department of Statistics, 1983.

<sup>3</sup> Chua Tee Tee (1977). A survey of exceptional individuals in selected countries of South-east Asia. *Jurnal Pendidikan (Journal of Education Research)*, University of Malaya, 7, p.50.

As indicated in Table 2, the total number of exceptional children and youth enrolled in special schools and centres as at the end of 1984 was only 4,220, or 2.5 percent of the estimated numbers.

**Table 2**

Percentage of Estimated Numbers of Handicapped  
Children and Youth Enrolled in Special Schools/Classes  
in Malaysia, December 1984\*

Type of Handicap	Number Enrolled	Estimated Population	Percentage Enrolled
Visually Handicapped	442	1,979	22.3
Hearing Impaired	2,000	22,758	8.8
Mentally Retarded	,453	72,233	2.0
Physically Handicapped (including cerebral palsy cases)	393	71,738	0.5
TOTAL	4,220	168,708	2.5

\*Ministry of Education, Malaysia.

The mass media, particularly television, radio, newspaper and cinema, should be used more frequently to publicize the existence of special education and rehabilitation services for exceptional individuals and to urge parents to send their children for diagnosis, registration, treatment and education. In the meantime, both government and private organizations are urged to expand physical facilities so as to reduce the long waiting-list for admission of exceptional children, particularly the mentally retarded and the physically handicapped.

### CONCLUSION

Much has been done for the education of exceptional children and youth in Malaysia. There are facilities for the education of visually-handicapped, hearing-impaired, mentally-retarded and physically-handicapped, and/or cerebral palsied children. There are local one-year training programmes for teachers of the visually-handicapped, hearing-impaired and children with learning problems. However, much more needs to be done. Special school places need to be increased substantially, the special needs of children with chronic health problems or children who are mentally gifted need to be met, the quality of existing facilities has to be upgraded and more government support to existing private organizations has to be forthcoming. It is very encourag-

ing to note that the Malaysian government has steadily increased its annual allocation for special education from M\$791,309 in 1970, to M\$1,813,000 (129 percent increase) in 1984 (Wan Kalthum, 1985). The equality of education must be interpreted as the right of every child to an equal opportunity to develop his potentialities to the full. Special education should aim at making disabled people become taxpayers and economically independent self-respecting citizens.

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## **INTERNATIONAL TRENDS IN THERAPEUTIC COMMUNITIES AND COLLECTIVES**

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*This article describes three major types or models of intentional communities that have been developed for young people and adults who have difficulties finding a place in ordinary society. One type is based on medical or psychiatric concepts of pathology. A second model draws upon religious or mystical perceptions of the sanctity of the individual. Finally, there is in Scandinavia an increasing number of Makarenko-inspired collectives for alienated youth which have grown out of the counter-culture movement. In Sweden and Norway, the collectives have been established especially for young people addicted to alcohol and drugs, whereas in Denmark they serve a broad range of children and adolescents with severe adjustment problems. These collectives show vitality and relevance to the needs of troubled youth at odds with contemporary Western culture and might be considered as alternatives for interventions in other countries as well.*

This article presents a survey of current approaches in working with handicapped and maladjusted young people by means of planned or international social groups. They include the therapeutic communities which were originated by Maxwell Jones in Britain, the spiritually oriented anthroposophic and L'Arche homes and villages found in many countries, and the Scandinavian collectives

for young people with drug addiction. Special attention is given the latter since they are little known outside the Nordic countries.

The tradition of using the community as an agent in healing has deep roots in Western civilization. Since the 15th Century the town of Gheel in Belgium has taken in the mentally ill as members of the family and the community. In recent years a comprehensive American-Belgian research project has been conducted under the leadership of Srole (1977) to discover the ingredients of the success of Gheel's ancient and natural therapeutic community and to outline the implications for modern psychiatric practice. During and after the French Revolution, the Paris physician Pinel experimented with what was called "moral treatment" of mental patients freed from the asylums. The approach was defined as an organized group living situation in which work, play, and social activities would produce meaningful life experiences leading to individual growth.

### **PSYCHIATRIC THERAPEUTIC COMMUNITIES**

The term "therapeutic community" came into use right after the Second World War to describe new directions taken by British psychiatrists in working with soldiers suffering from emotional traumas related to their war experiences. The concept of the therapeutic community and related terms such as "therapeutic milieu" and "social psychiatry" have been especially associated with the British psychiatrist Maxwell Jones and his experimental programs both in England and in the United States. In a number of books starting with *Social Psychiatry: A Study of Therapeutic Communities* (1952) he has outlined the principles and practices of using the social setting as a crucial instrument and technique in treating psychiatric problems.

Through his writings and his examples, Maxwell Jones has had an enormous influence on the treatment of people with adjustment problems both in medical, educational, and non-traditional settings. His ideas have been adopted and often modified to fit other kinds of disabilities and other theoretical assumptions quite different from his egalitarian principles.

### **COMMUNITIES WITH A SPIRITUAL ORIENTATION**

During the past half a century, two major therapeutic movements have arisen which are based on drastically different conceptions on handicap and

normality. They are critical of the increasing dehumanization in society and the loss of spirituality in human relationships. They oppose traditional practices in the treatment of the handicapped, and they search for new ways of caring and curing.

### ***L'Arche***

L'Arche or the place of refuge was founded by a Canadian, Jean Vanier. His father was ambassador to France and later Governor-General of Canada. With his deeply religious nature, Jean Vanier was abhorred by the cruelty of the world and particularly the devaluation of the weak and disabled. In 1964, he started in France with patients from a state hospital a small community in which handicapped and non-handicapped lived together in a spirit of unconditional love and meaningful attachment. There are now about 60 established L'Arche communities in more than a dozen countries. Of these, 18 are in Canada and seven in the United States; many more are in the process of formation. A cardinal goal in these communities is to develop self-sufficiency and independence. There is also a wariness of traditional professional roles and treatment approaches (Wolfensberger, 1973).

### ***Anthroposophic Schools and Villages***

A similar form of therapeutic community has evolved from the teachings of Rudolf Steiner, an Austrian religious philosopher, educator, and social reformer. His philosophy, called anthroposophy, is Christian, but with elements of Oriental mysticism, including a belief in reincarnation. Dozens of villages based on Steiner's principles can now be found in many countries. They have reached their most distinct expression in the so-called Camphill villages, taking their name from a farm in Scotland where the first one was started in 1939. In these communities, the handicapped and non-handicapped live together in a spirit of equality and mutual sharing. One of their tenets is that the welfare of a community is greater the less each person claims for himself the products of his labor and the more his needs are met by the work done by others. Thus all income is shared and distributed according to need. There is also an emphasis on beauty and the arts and harmony with nature, and all farming is biodynamic (Juul, 1979; Richards, 1982). Zipperlen (1975) a leader of Kimberton Hills in Pennsylvania has outlined some basic principles of a Children's Village:

. . . staff and children live together in community with a common task, the education of the children in a therapeutic envi-

ronment. This environment is the cumulative result of (1) the shared home life of the staff, their own families and handicapped children in the houses of the village . . . (2) artistic activity and artistically based therapies creating a harmonizing whole of which the architecture of each building is a part; work and play in a healing setting of woods, fields, gardens, and animals, and shared responsibility for their care and development; (3) emphasis on experience of the rhythms of day, week, and year, the changing seasons and different festival times; (4) a school curriculum based on the development of the whole person in accordance with chronological age, not confined to intellectual achievement (p.272).

Like L'Arche, the anthroposophic communities have predominantly served the mentally retarded and multiply handicapped. However, some are designed for other disabilities, such as drug addiction. Best known of these is the Seven Dwarves, a farm community in West Germany with a success rate of 95 percent. Holistic medicine, closeness to the earth, a caring fellowship, and spiritual renewal seems to have provided the formula for this achievement.

In some European countries, anthroposophy is a well recognized alternative in therapeutic education. In North America, it is hardly known at all, although some very fine farm communities and schools have existed for years in New York and Pennsylvania. More have recently been started in other states and in Canada.

### ***Makarenko-inspired Collectives***

In socialist and communist countries children's collectives have a special role in the social and moral education of the future citizens. Csapo (1984) has provided a comprehensive description of the characteristics and major objectives of these communities. They include a positive attitude towards productive work, a heartfelt striving to create a better world, the development of responsible leadership and fellowship, self-discipline, and self-evaluation. The collectives have also been effective as interventions with deviant behaviors. In Russia, Makarenko used them right after the communist revolution in the re-education of delinquent and antisocial youth. His experiences have been dramatically described in his book, *The Road to Life* (1955).

In Scandinavia, Makarenko's educational and therapeutic principles have since around 1970 become the guide for the formation of a number of collectives particularly for young people with problems of substance abuse and serious

social maladjustment. Inspired by socialist idealism and the counter-culture movement of the time, socially conscious reformers began to create small communal settings for adolescent boys and girls who had failed in the usual treatment apparatus.

### **Sweden**

The first collective was started in Sweden in 1969 by an educator, K.A. Westberg, who had been director of a special school. Despairing of the apparent futility of traditional approaches to the treatment of young people, he established with some friends a fledgling collective on a farm in a remote rural area of Sweden. The place was called Hassela which has become the name for subsequent collectives that have followed a similar model. A 1980 publication *Hassela* describes the philosophy, principles, and intervention approaches of the collective as it has evolved over a decade. Some of them are summarized in the following list:

1. Drug addiction is a symptom of the alienation and dissolution of values that are the consequences of a capitalistic economic and social system.
2. Psychoanalytic, humanistic and behavioristic treatment modalities are inappropriate because they create the illusion that the cause of deviancy is within the person and not in the actual malfunctioning of the society.
3. Intervention consists of activating the young people to a political struggle for higher social values and greater social justice.
4. The medium of intervention is a small collective of less than 20 people in which staff and students live together as equals in a spirit of solidarity and common purpose.
5. Re-education goes on around the clock, on the farm, in the house, in the community, and in all the other activities in which the young people are involved. The staff take on many of the roles of parents in guiding, correcting, and serving as models for the young people.
6. The students accepted for the program are all in their late teens. It is believed that most of them have not fully lived their childhood as they have rushed into the phoney maturity of the drug culture. They are therefore given the freedom to step back into a younger age to feel defenseless and vulnerable but also to receive the comfort and protection to which every child has a right.

7. An important event in the reeducation program is an eight day wilderness adventure each fall to a cottage high in the mountains. Four of the days are spent walking there and back. The experience has a dramatic impact on many of the young people. Pride in achievement, fellowship, trust, and the enjoyment of the overwhelming beauty of the Harjedal massif in its fall colors lay the foundation for future growth.
8. During the second or third year of their program the students are enrolled at the Farsa Folk High School where they live with ordinary students. They only return to their collective on the weekends and in their spare time. This placement is an important step in their gradual return to independent living.

In parenthesis, the folk high school is a unique Scandinavian institution designed to help young people in responsible citizenship and democratic living and in the transition from childhood to adulthood. There are about 400 folk high schools in the Nordic countries. They are residential, and typically they have between 80 and 100 students who stay for one year. Many of the schools serve or integrate handicapped and disadvantaged youth (Juul, 1985).

After some reverses caused by an underestimation of the severity of problems burdening the young people, Hassela began to function well and to bring about remarkable improvements in their adjustment. Soon other similar communes began to take shape, and to the extent they have followed the original model, they are called Hassela collectives. Some of them cooperate with the Stensund Folk High School which has a tradition of working with alienated youth.

The original collectives were designed for youth in their late teens. However, many boys and girls who were only 14-15 years old had exhausted all other treatment methods and were in need of an alternative placement. In 1978, a collective for this age group was started at Martensbo Farm. It was based on the Hassela model but with some modifications. The stay was extended for four years. Because the young people were within the mandatory school age, they were also enrolled in a local public school. They were admitted to the collective in the month of March and thus had a five months period to get adjusted before school began.

The program had the following four stages. The first year was devoted to basic upbringing and care. The second year was one of consolidation during which the young people helped the newcomers. During the third year, the



students went to a senior high school in a neighboring town and returned to the collective during holidays and vacations. The fourth year set the stage for eventual independence and planning for the future. According to experts, the results have been astounding with a nearly 80 percent success rate.

The Hassela collectives have served as an inspiration for the development of similar therapeutic communities in two other Scandinavian countries, Norway and Denmark.

### **Norway**

In Norway there was an immediate and positive reaction to the news about the Hassela collective. Already in 1970 two idealistic young professionals in a psychiatric agency established a similar rehabilitation project on an old neglected farm called Sollia. With assistance from the national council on drug abuse they received funding for machinery, cattle, and other necessities. Since then the collective has grown and prospered. New buildings have been constructed and the acreage expanded. The farm has substantial milk production. Presently, three families whose members are former clients live there with their families and have responsibilities in the program. The reputation of the collective is now so good that only one out of nine applicants or referrals can be accepted for treatment.

A more recent collective, Tyrili, was started in 1980 to address the needs of younger drug-dependent youth, ages 16 to 18. It was soon discovered that considerable changes had to be made in the original Hassela model. The psychological damage the young people had suffered was considerable. As an average they had been drug abusers for 5-6 years. Some could not eat or dress themselves properly. Their information level was often very low, and some could not read or write. It was clear that the typical methods and expectations in the Hassela collectives were inappropriate. These children needed massive infusions of basic caring and opportunities to live through a childhood which had never existed for them. It also became obvious that some youths were so emotionally disturbed, violent, or psychologically devastated by their drug abuse that they were unable to function in the collective. The selection process thus became an important factor in the therapeutic planning.

Because of the young ages, the vulnerability, and the educational problems of the residents a new approach has evolved with some new and distinctive features. The 36 months' stay is divided into the following phases:

1. A one month camping experience,
2. A three months' introduction to the life of the collectives,
3. Twelve months of school attendance in the collective culminating in a four-week trip to the Mediterranean,
4. One year as students in a public school while living together as a group, and
5. Eight months of reintegration in their own community while going to school or holding a job.

One of the Norwegian collectives, Klokkegarden, has emulated the Swedish Mortensbo model in accepting 13 to 15 year olds with substance abuse. A detailed description of how this children's community was started has been provided by the psychiatrist Helge Waal (1984). The Klokkegarden collective started in 1981 after careful planning, which included the coordination of participating agencies, involving the parents, educating the local community, seeking the help of administrators, teachers, and students at the neighborhood public school, and the selection of staff. Most of the staff, or grown-ups as they are called, have had previous experiences in collectives, and all have skills in the practical vocations such as carpentry and farming. The children selected were considered complete failures in previous treatment attempts.

The Norwegian collectives have in a decade and a half grown in numbers, effectiveness, and in public recognition. A 1984 issue of the journal *Stoffmisbruk* (substance abuse), which is the organ of the Central Council on Narcotics Problems, contains a list of more than 60 hospitals, centers and other facilities for young people with narcotics and alcohol problems. Of these, six are listed as Hassela-type collectives. However, other places are known to emulate the model to at least some extent.

The ministry of Social Affairs has established a special office on alternative treatments under the leadership of Helge Waal, who has published a series of penetrating and sympathetic observations on these programs both in Norway and in other Scandinavian countries (Waal, 1980).

For a number of reasons the Norwegian collectives have moved in a different direction from the Swedish prototype. Their anti-establishment and anti-psychiatry fervor has lessened. With younger and more difficult clients the leaders have recognized the limits of what this kind of therapeutic setting can do. They have become aware of the need to work closely with the traditional agencies and professions and to involve the community, particularly in after-

care. In the process, the collectives have become better accepted as legitimate alternatives in the treatment of young people with substance abuse and similar problems.

It is also of interest to know that during a visit to Norway in the summer of 1985 this writer found that the word "collective" in the span of a few years has entered into the common vocabulary of both professional and lay people. However, its meaning had been broadened or diluted to include almost any kind of group treatment of young people with problems. Many are not aware of the term's origin in radical political ideology.

### **Denmark**

In Denmark, the first collective community was started around 1970 by a group of professionals to provide a home for about a dozen clients between the ages of 8 to 15 with social deviance and behavioral disturbances. The place was called Child Center Fjordhoj. The main therapeutic thrust was focussed on meaningful practical activities such as household chores, construction, car repairs, gardening, and fishing. No one received a salary, and allowances were adjusted to age. Major decisions were made in meetings where all could vote. Funding came from social agencies responsible for the youth. The ideology of the program was anti-institutional and egalitarian.

The ideas from the Fjordhoj Center spread rapidly in Denmark. Within less than a decade more than 200 similar groups were recorded throughout the country, of which 15 originated with the Fjordhoj project. These collectives have united in an organization which provides a mutual support network, and they share their experiences with each other through their own newsletter (Waal, 1980).

There are at present three major forms of these arrangements or milieus, as they are often called: collectives for younger children, developmental collectives for young adolescents, and production collectives for older youth which stress economic independence. Best known of these is Majgarden, a production collective. It is situated a few miles outside the city of Horsens in an old school building erected at the turn of the century. Life in this milieu has been movingly described in a book by two of its leaders, Morell and Kerrn-Jespersen (1981).

The community is run on egalitarian principles, and all income is shared. The responsible people or staff are called "the old ones" and the young people in need of help "the young ones". The youth all come from homes that have dis-

integrated and they have a record of school failures. They are referred from prisons, psychiatric hospitals, and similar treatment centers. One 17 year old boy had a record of 36 different institutional placements. The philosophy is anti-psychiatric and the young people are looked upon as victims of a society that has no room for them. Re-education takes place in all the daily activities in which everybody has responsibilities. Problems are dealt with in group meetings. A fundamental concept in the collective is solidarity, and each person is regarded as having abilities and resources that can contribute to the common good. Much learning and growth — and income — is engendered around an old 17-ton fishing vessel "Makarenko". The boat which takes a crew of seven is usually out at sea several days at a time, and much of the catch is sold on auctions or distributed to other collectives. The ship is also used for vacation trips as far away as Finland.

The healing process shows in many and often unexpected ways. Thus some of the young people learn spontaneously to read or do arithmetic and become interested in going back to school. Youngsters who are too skinny put on weight, and some who are too heavy lose their excess fat. Above all, they grow emotionally and socially and learn to take hold of their own lives.

A leading spokesman for the counter-culture movement and the collectives in Denmark is Benny Lihme, a university psychologist and the board chairman of a collective for children from Copenhagen. A reason for his involvement is the very negative empirical results of treatment efforts in traditional treatment homes (Lihme, 1980).

## CONCLUSION

The use of a caring community as a medium of healing has a long tradition in the Western civilization. In the past several decades three major different types or models of intentional communities have emerged for young people and adults who have difficulties in finding a place in ordinary society. One type is based on medical or psychiatric concepts of pathology, particularly those of Maxwell Jones. A second model draws upon religious and mystical perceptions of the sanctity of the individual as expressed in the teachings of Jean Vanier and Rudolf Steiner. Finally, in Scandinavia there is a flowering of Makarenko-inspired collectives for alienated youth which have grown out of the counter-culture movement. These collectives show vitality and relevance to the needs

of troubled youth at odds with contemporary Western cultures and might be considered as alternatives for interventions also outside the Nordic countries.

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## BOOK REVIEW

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***Therapeutisches Reiten im Rahmen einer komplexen  
medizinischen Rehabilitation.***

*(Therapeutic riding within the framework of comprehensive medical rehabilitation). Halle-Wittenberg, German Democratic Republic: Orthopedic Clinic and Polyclinic at the Martin Luther University, 1980, 77 pages.*

Reports from Eastern Europe about the treatment of emotionally disturbed and socially maladjusted children are rare. It was therefore a pleasant surprise to receive from East Germany or the German Democratic Republic a publication showing that in that country there is much concern for behavior disordered children and sophisticated and innovative approaches to their treatment.

*Therapeutic riding within the framework of comprehensive medical rehabilitation* is a compact little volume which contains the proceedings from a conference at the Martin Luther University in November, 1979. It has nine chapters of which five are reports on treatment programs in children's psychiatric hospitals. Most of the contributors are physicians, the rest physiotherapists. This review presents some general information about riding therapy in East Germany, brief summaries of three chapters dealing with behavior disordered children, and some final comments.

In East Germany riding therapy as a treatment for physically handicapped children began to gain ground in the 1960's. In 1971 a professional riding therapy association was formed, and in 1973 legislation was passed which qualified riding therapy to be reimbursed by the national health service if it was prescribed by a physician and carried out under the supervision of a trained physiotherapist. By 1979 there were about 50 medical facilities and 250 specially trained physiotherapists using riding therapy. Most of the child patients suffer from scoliosis, spasticity or other physical disorders, but increasingly psychiatrists are employing this intervention with children who have psychiatric problems.



The Child Psychiatric Clinic in Halle has a holistic and multi-disciplinary treatment philosophy that includes milieu, psychological, behavioral, occupational, and physiotherapy. Riding therapy is looked upon as a treatment method that deals with the total personality and not with specific symptoms. It is believed that as improvements occur in the central disturbances, the symptoms tend to lessen or disappear. An example of this is the frequent progress in speech and language skills observed in children participating in riding therapy. In a systematic study of 46 children, 10 children or 22 percent made outstanding progress as a result of riding experiences. The diagnostic categories to which they belonged were neurosis, enuresis, mutism and autism, and anorexia. In addition, the success in riding therapy made the other therapies more effective, but the children's progress appeared to be more related to the total situation. It also turned out that for some especially difficult children the opportunity to ride horseback became a powerful reward for appropriate behaviors in other situations.

At the Hospital for Child and Adolescent Psychiatry in Wechselburg a close relationship is perceived between motor development and personality. It is believed that gaining physical skills and competencies reduces anxiety, improves self-confidence and affective functioning, and furthers the communication process. For this reason there is much emphasis on such activities as creative movement, rhythm, swimming, trampoline, and skiing. In riding therapy, a close and trusting relationship between the child and the horse is considered of major importance as is the emotional support of the group. The staff has found it difficult to document the effectiveness of the riding therapy partly because of the inherent problem of measuring behavior changes, and partly because the riding therapy is only one link in a complex and comprehensive treatment program. Still an assessment has been made with regard to the children's adaptation to the riding situation. A total of 105 boys and girls ranging in age from six to 12 were given two weekly 120 minute riding therapy sessions at a stable. This took place in groups of four. Detailed observational records were kept on each child and tallied on a four-point adaptation scale. The improvement was statistically significant.

There is also a lengthy report on the riding therapy program at the Child Psychiatric Clinic of the Karl Marx University in Leipzig. The program has been in operation since 1972 and over 200 child patients have participated. A systematic study has been made of 98 children, 53 girls and 45 boys ranging in age from 5 to 17 years. Of these, 76 were diagnosed as neurotic, seven had schizo-

phrenia and two had bad depressive psychoses, six had behavior disorders without a neurotic genesis, six presented "abnormal personality development", and one was brain injured. The average number of riding sessions was 11. The assessment had two aspects. One was a 50 item scale depicting the progress in riding skills, ranging from "Sitting on the horse with the support of the therapist" to "Galloping with both hands free." The other measurements dealt with (a) relationship to the horse, (b) cooperation in riding, (c) behavior at the stable, and (d) general relationships with other children and the staff. In summary, the best results were gained with children characterized as inhibited, anxious, and depressed and those troubled by contact disturbances, inferiority feelings, and reduced ability to see things through. The least progress was made with aggressive children who had a weak capacity for empathy and self-control. It was suggested that they might do better in a more controlled and demanding setting.

The papers convey the impression of a flexible and un-doctrinaire approach to diagnosis and a humanistic and eclectic orientation to treatment. Sincere efforts were made to document and provide scientific evidence to support the procedure. For readers critical of the heavily medical orientation, it must be mentioned that in East Germany as in some other European countries horseback riding is also an important component in special education and in recreation for the handicapped. In those programs there is no medical supervision and obviously no reimbursement through the health insurance system.

In the United States riding therapy is only beginning to be recognized as an educational and a therapeutic medium. Some are afraid of the physical dangers involved. They apparently need not fear. In a national survey in East Germany it was reported that during 445,200 riding sessions there had been only 10 injuries.

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