ISSN 0827 3383

International Journal
of
Special Education

VOLUME 9 1994 NUMBER 1

INTERNATIONAL ASSOCIATION OF SPECIAL EDUCATION

International Journal of Special Education

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International Journal of Special Education

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Proceedings of the Third Biennual Conference, University of Vienna, July, 1993.

VOLUME 9 **1994** **NUMBER 1**

International Journal of Special Education
1994, Vol. 9, No. 1

REDISTRIBUTION OF SPECIAL EDUCATION RESOURCES IN SOUTH AFRICA: BEYOND MAINSTREAMING TOWARDS EFFECTIVE SCHOOLS FOR ALL

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Most African children with special needs are currently mainstreamed, not because it is considered to be the best option, but because it is the only alternative. The logical solution would seem to be to simply to create one education system for all ethnic groups, accept mainstreaming as a fait accompli and optimize it by redistributing the services, resources and personnel now nearly exclusively reserved for whites. Practical considerations and philosophical reasons why this option will not suffice are presented. The flaws of mainstreaming are highlighted by comparing it to the regular education initiative (REI). It is suggested that the adaptive learning environments model (ALEM), in combination with a community based rehabilitation approach (CBR), incorporating the principles of People's Education, and paying more attention to prevention, may provide some of the answers for South Africa.

South Africa is a country smothered by problems awaiting solutions. Hugo and Stack (1992) observe that there is also an oversupply of solutions, the basic assumptions and operationalization of which are rendered problematic by the uncertainties regarding the nature of the successor state to come. Public policy initiatives are caught up in a vacuum which permits little more than speculatively informed contingency thinking and planning. Any attempt to address the panoply of national problems should therefore be imbued with a strong sense of self-scepticism. The predictions and suggestions in this paper are put forward in this spirit.

The changing nature of South African political life is the macro context of the need to redistribute all human and material resources in the country, including educational resources (Unterhalter, Wolpe, Botha, Badat, Dlamini & Khotseng, 1991). Indeed, the present turbulence in the political and all other systems may be seen as the precursor to a number of dramatic trend breaks in South African society.

In terms of futures theory, the chaos associated with major societal transformations offer the opportunity for creative change. This paper will focus on the redistribution of special education resources in a time of general and fundamental upheaval. The reason for this special concern is that the disabled are an especially vulnerable group in the face of impending restructuring of political relationships and the entire system of education. In a country where the majority is only now beginning to assert its fundamental human rights, the disabled are among the voiceless minorities who run the risk of being sacrificed in times of economic hardship (Wilson & Ramphele, 1989).

Indeed, the South African economy has been in the doldrums for the past two decades, with the average growth rate at a stagnation level of 0.7 per cent per annum, less than one-third of the population growth level (Hugo & Stack, 1992). Following Human (1992), redistribution refers to the creation and redistribution of wealth, or surplus value. The concept includes but transcends financial wealth; it may also include empowerment. Nevertheless, it is a sobering reality that in the context of a national education budget already stretched to the limit, and even after more equitable redistribution of the presently rather lavish resources for whites, future services will have to make do with less money. There probably will not be much surplus wealth to redistribute in this country for some years to come.

Status Quo

The status quo might be best described as special education for whites, while services and resources for black pupils are vastly inadequate and nonexistent in some areas (Donald, 1991; Hickson & Kriegler, 1991). Since there has been no compulsory and free education for Africans, there has been little commitment to provide services for those school-aged children not able to learn in the traditional classes (Gwalla-Ogisi, 1990). Worse, there is no process whereby the numbers of children dropping out of school because of handicapping conditions could even be tabulated (PASA, 1989). African children are over-represented in the mental retardation category. Some estimates put the incidence of mild and moderate mental retardation at four per cent of the total African population (Gwalla-Ogisi, 1990). It goes without saying that such estimates are tendentious, bearing in mind the virtual absence of adaptive and intelligence tests that have been developed for and normed on Africans. The point is that scant educational provision exists for those children in need of it.

This is even more true for African children who would, if assessed, fit within the labels of specific learning disabilities, mild behaviour problems or giftedness. In the words of Nomsa Gwalla-Ogisi (1990, p. 276) children with learning problems in African schools are mainstreamed ... not because it is a terrific idea and state of the art innovative practice, nor because it is a practice deemed the best for handicapped children, but only because it is the only alternative. The issue becomes that of efficiency in educating all children who can afford to be in school, i.e. providing any setting at all for children.

This state of affairs is tragic bearing in mind that Africans, in large part because of apartheid policies, are more vulnerable to all the handicapping conditions, especially those associated with poor living conditions, mal- and undernutrition, disease and accidents (Burman & Reynolds, 1986; Platzky & Walker, 1985; Wilson & Ramphele, 1989).

The Logical Solution: Mainstreaming

As Green (1989) pointed out, the resources for special education will be scarce for some time to come. Any available resources are likely to be channelled into separate provision for children with severe handicaps, while the majority of black children with special educational needs will remain in the regular classroom. Following Tungaraza's (1992) prescription for Tanzania, the logical solution would seem to be simply to create a unitary education system for all ethnic groups (a process already under way), accept the present reality of *involuntary* mainstreaming as a fait accompli, and optimize it by a process of redistributing the services, resources and personnel presently exclusively reserved for whites.

This option, although it will certainly go a long way towards assuaging real and perceived injustice, will however not suffice. Engelbrecht (1991) calculated that after redistribution of the grossly skewed distribution of educational psychologists who are still mainly accessible to white children, the overall ratio of professionals to pupils will remain at the unrealistic level of 1:12 000. Donald (1991) concurs with Engelbrecht that the individual referral system will remain inadequate and inappropriate because of the huge lack of trained personnel. The same equation applies to special educators, school counsellors, remedial teachers and other professionals who are trained to work with children with special needs.

In addition, past and present training has not resulted in educational psychologists or other special education personnel being adequately or appropriately prepared for the problems of African pupils, schools and communities (Kriegler, 1988). Eurocentric psychology and educational psychology does not necessarily have universally applicable values, and their insensitivity to oppression and the dynamics of social and cultural transformation has been extensively argued (Foster, 1991; Manganyi, 1991; Swartz, 1991). Also, special education approaches and techniques imported from Western societies are not always appropriate in developing communities (Addison, 1992), and training of special educators for these communities pose special problems and challenges in regards to relevant and practical curricula (Chang, 1992).

Apart from these practical problems there are fundamental considerations that have been articulated and crystallized in education systems throughout the world over the last thirty years that compel us to think beyond mainstreaming. These will be touched on in subsequent sections, with special reference to the American and the British experiences. The paper will conclude with lessons for South Africa.

Beyond Mainstreaming

Given the enthusiasm with which the then bold development of the 1970's, such as the Public Law 94/142 in 1976 in the United States, and in Britain the 1978 Warnock Report were greeted, it may be asked *why beyond mainstreaming?* At the time, this seemed such an enlightened and progressive sentiment which held the promise of a fairer deal for the handicapped and the bonus of the emergence of a more humane and compassionate society as those virtues rubbed off onto the nonhandicapped peers. What went wrong? The answer to this question is inherent in the characteristics of mainstreaming.

In the USA, mainstreaming provides for identified individuals designated as handicapped whatever it takes by way of additional services and resources to enable that learner (because of his/her characteristics and deficits) to receive appropriate educational and related experiences in the context of the least restrictive environment according to specified routes and channels (Henderson, 1989). This means that benefits are still contingent upon labelling, services are seen as *additional* to education and not inherently part of it, while *least restrictive environment* is a negative rather than a positive concept. In the USA, the funding for benefits is channelled in terms of category of handicap or by special votes and allocations. Services may be constrained by the emphases of individualized educational programmes (IEP's). In Britain, the length of time taken to *make a statement* about a child's special needs remains a problem (statementing can take as long as a year), and the question whether a Statement does in fact make a contribution to a child's educational experience remains moot (Webster, 1989).

Most importantly, the philosophy of mainstreaming leaves regular educational practices unquestioned, at least from the perspective of low-achieving pupils. Following the Warnock Report in 1978 and the British mainstreaming legislation based on it, many *ordinary* children whose needs are not being met in *ordinary* classes were still being overlooked (Brennan, 1982), and Galloway asked: *The question is whether a curriculum and an emotional climate which fails to cater for up to 20 percent of pupils can be entirely suitable for the remaining 80 percent.* Mainstreaming is a piecemeal response to a whole school issue.

The Regular Education Initiative

The *Special Education Initiative* which arose in the early sixties depended largely on a psychological perspective of special educational needs. Up to the eighties only isolated voices questioning its underlying assumptions were heard. Then, at a conference in 1985, Madeleine Will, then Assistant Secretary for the US Office of Special Education and Rehabilitation Services, proposed a single, co-coordinated delivery system and experimental trials of more integrated systems for those for whom segregated education cannot be justified (Ainscow, 1991). This was the start of serious attention being paid to the Regular Education Initiative.

The flaws and limitations of mainstreaming may be highlighted by comparing it to the characteristics of the *Regular Education Initiative*, also known as the *Whole School*

Movement. It conceives of special educational needs as a more fundamental aspect of school improvement and attempts to improve the quality of schooling for all pupils. This may well be the most advantageous way of responding to those who come to be described as having special educational needs (Solity, 1991). The movement questions the continued existence of special education as a separate field of operation. It draws information from psychology, sociology, political theory and curriculum studies, and the research on effective schools, school improvement, classroom practice and staff development. It is perhaps best exemplified in Wang and Reynolds's Adaptive Learning Environments Model.

The Adaptive Learning Environments Model

Wang's (1991) *Adaptive Learning Environments Model* (ALEM) proposes full-time placement in general or neighbourhood settings. Support and services are delivered within the general setting as an integral part of that setting. The approach depends on teacher assistance teams, explicit channels of access and accountability, and specialist information and backup. Co-ordination of resources is one of the mechanisms of implementing the principle of optimization of existing resources. Consulting learning personnel might advise regular teachers on appropriate techniques, such as co-operative learning, and the application of proven methods, e.g. *Direct Instruction, Mastery Learning* and *Precision Teaching*.

It is a flexible approach, comprising multiple, even competing and contrasting models of service provision. It comprises highly structured instruction to develop academic skills, complemented by an open-ended exploratory approach to social and personal development. Students plan and manage certain aspects of their own curriculum, including group work across age and abilities. ALEM implies IEP's (or Statements) for all. Each pupil is entitled to individually developed educational plans to accommodate strengths and needs as they change across time. The model provides for the professional and career preparation of pupils. It depends on flexibility of organizational arrangements, instructional groupings, curricular resources, staffing, and the use of peers, parents and volunteers.

This kind of model obviously moves beyond the limitations of a purely psychological model towards a socio-ecological perspective. It draws from sociology and is sensitive to curricular issues and funding priorities. It depends on effective deployment and redeployment of personnel. It is a multicultural perspective, accommodating geographic and demographic realities and trends, which will be a strong point in view of the probable decentralization and regional autonomy in education systems in a future South African dispensation. The most significant strength is the model's ability to accommodate change, because it is essentially a change perspective.

Implications for South Africa

In a country where the school, the organ set up to provide education for children, has in so many ways failed to do so, it is time to look beyond the individual child and her/his characteristics (Christie, 1990; Everatt & Sisulu, 1992; National Education Conference, 1992). Under the best circumstances it is impossible to draw an accurate dividing line between children who have special educational needs and those who do not (Apter, 1982). To accurately determine and assess inherent learning or emotional deficits in a society where intellectual underdevelopment, emotional and psychological trauma, cultural and environmental deprivation are so common as to be almost the norm, is very difficult if not impossible (Kriegler, 1989). Some estimates put the percentage of pupils who suffer from policy-related and system-created delays, underdevelopment and underachievement at higher than 50 per cent. At any rate, the following facts are staggering:

1. Half of all African children who enter school do not pass Standard five (Grade seven) in seven years.
2. Only one in 10 000 African students passing Standard 10 (Grade 12) obtain a higher grade pass in Maths.
3. The Standard 10 pass rate for African pupils has fallen from 52 per cent in 1989 to 36 per cent in 1990 (National Education Conference, 1992).

A number of authors have begun to urge systems level inputs by educational psychology (Donald, 1991; Metcalfe, 1987; Sibaya, 1987), although there is generally a frightening lack of expertise in grappling with the bigger picture. Obviously what is needed is a re-conceptualization of what we mean by educational difficulty. These words of Ron Edmonds (cited in Ainscow, 1991, p.1) are especially relevant to the South African situation:

> We can, whenever and wherever we choose, successfully teach all the children whose schooling is of interest to us.... Whether we do it or not must finally depend on how we feel about the fact that we haven't done it so far.

The withdrawal approach, the remedial approach and the mainstreaming approach to special education, although they have different methods and strategies, continue to perceive the problem as being the child's. In attempting to conceptualize educational difficulty in a more positive way, we can more usefully see pupils experiencing difficulty as indicators of the need for reform (Ainscow, 1991). Such reforms would be to the benefit of all pupils, provided that these reforms are sensitive to traditional cultural values and the real needs of the communities who are to benefit from them (Fuglesang, 1982; Keto, 1990).

Back to the Basics

In line with the ideas propagated by the Regular Education Initiative of the nineties, we need to get *back to basics* regarding special educational needs in South Africa. If, as many of the movement's proponents have urged, we scrap the notion of *mildly handicapped*, we will be left with a much smaller number of children in need of special services. Quite apart from the financial impossibility of providing services for the *mildly handicapped* in a context where ordinary needs like basic text books and desks can hardly be met, there are sound educational and philosophical reasons for abandoning the *soft* categories (Senf, 1981).

A case in point is the specific learning disability category. Many have convincingly argued that the concept is psychologically indefensible, the interventions associated with it expensive as well as ineffective, and its jargon discriminatory (Bartoli & Botel, 1988; Coplin & Morgan, 1988; Forness, 1988; Poplin, 1988). Ironically, and unlike the *hard* categories, society can accommodate the mildly handicapped, whereas the school cannot cope with them. Much the same may be said of mild mental retardation.

In this country, where the majority of black scholars are scholastically underachieving due to the effects of environmental, socioeconomic and cultural deprivation, as well as all too often vastly inadequate educational provision in the ordinary schools, the question is whether we can afford the luxury and the waste of providing special services for *specific learning disabilities* - a seemingly arbitrarily selected, but unmistakeably middle-to upper-class group (Gelb & Mizokawa, 1986). In a country where providing more schools has not succeeded in achieving functional literacy for the masses, a special education system designed to identify and remedy *dyslexia* is ludicrous. We must give all of our children, not labels, but the right to read (Young & Tyre, 1983).

Whether we call children who struggle to become literate *slow learners, culturally disadvantaged*, or *learning disabled*, we are still *blaming the victim*, implicitly seeking the deficit in the learner. The result is that we do not question the nature of the instructional environment that has not been successful in developing literacy skills (Bartoli & Botel, 1988). Even a superficial inspection of black schools as literacy learning environments would reveal their tragic inadequacy in this regard (Kriegler, Ramarumo, Van der Ryst, Van Niekerk, & Winer, in press; Mashile, 1991).

We certainly do not need to repeat the mistakes made elsewhere in the world. Although in this country the *specific learning disability* field is also a heavily politicized concept entrenched by teaching departments at universities and training colleges, special schools and classes (almost exclusively reserved for well-to-do whites), we have learned valuable lessons from the ongoing American and British stock taking. We may implement these lessons to reform South African education from the roots, by making the best of what we have: the hitherto ignored resource of people's power.

Empowerment of Pupils, Parents, and Teachers

Linking up with the philosophy of People's Education (Nkomo, 1990), any future education system will have to accommodate the full diversity of and redistribute the only real *surplus wealth* we have: the people. The exclusion of parents in the education of their children has been a major stumbling block in regular no less than in special education (Gwalla-Ogisi, 1991). The disempowerment of teachers have contributed to the crisis in the schools and the disregard for children's rights and expectations have led directly to the massive disruption of the entire education system which has continued since the middle seventies till the present (Hyslop, 1990; Naidoo, 1990).

The role of the family and the community in dealing with some of the serious impairments could be enhanced by providing community centres where families could receive information, material assistance, and support. Community based rehabilitation (CBR) for the profoundly handicapped must be available and accessible, aimed at enabling children with disabilities to participate in community life and to promote human dignity (Helander, Mendis, Nelson, & Goerdt, 1989). The *objectively* disabled categories should be accommodated in comprehensive schools where recreational, medical and paramedical resources and services are made available to multiple categories. Such schools could function as resource centres, doing preventative work, informing and sensitizing communities, and offering careers education, as well as possibly life-long care for those who cannot be cared for in the community. Disabled persons should themselves have the opportunity to participate in policy making, preferably at a central government level by consultation with the various national councils for the disabled.

The efficacy of parental involvement has overwhelming research support; the fact is that parents are the key factor in children's growth, cognitive development, literacy development and general school learning (Hannon & Cuckle, 1984; Mittler & Mittler, 1982; Topping, 1982). The aim of parental involvement is not to try to change the parent into a professional teacher, but rather to augment existing parenting skills. Although wary of unbridled power in the hands of the pupils themselves, Du Plessis (1993) suggests the ideal of a negotiated curriculum. Other potential partners are the private business sector and trade unions.

However, the brunt of any proposed reform will no doubt be borne by those at the chalk-face. This paper does not pretend to offer answers to all the difficult questions facing teachers in overcrowded and under-equipped classrooms (Green, 1989). Nevertheless, it will be helpful if teachers are trained at a pre-service and in-service level to implement proactive and preventative strategies and teaching approaches. Other *third world* countries have developed schools for all children, regardless of race, handicap or economic status, which demonstrate that teacher skills determine the success or failure of children in school, rather than the classroom's label or handicapped-segregated status (Gwalla-Ogisi, 1991). Support teams consisting of speech, language and reading specialists, psychologists and other professionals as members of backup teams should further empower regular educators. Teachers should be empowered to work within a collaborative problem-solving culture, forming dyads, groups and networks.

Teachers should know a lot more about the sociology of the school as institution. Psychology is only one, rather narrow way of looking at, thinking about and responding to what goes on in schools. Teachers must be sensitized to strategies for democratization of schools and classrooms, empowerment of pupils and parents and enabling the disabled. It is worth bearing in mind the features that are common to effective schools (Ainscow, 1991, p.4):

1. Effective leadership from a head teacher who is committed to meeting the needs of all pupils.
2. Confidence amongst staff that they can deal with children's individual needs.
3. A sense of optimism that all pupils can succeed.
4. Arrangements for supporting individual members of staff.
5. A commitment to provide a broad and balanced range of curriculum experiences for all children.
6. Systematic procedures for monitoring and reviewing progress.

Schools should be geared to be problem-solving organizations within which everybody, pupils, teachers, and parents, is engaged co-operatively in the task of learning. *The search for excellence in schools is the search for excellence in people* (Clark, cited in Ainscow, 1991, p.9).

Prevention is Better than Cure

The first right of any disabled person is not be disabled, never to have been disabled (Zargoza, cited by Skrtic, 1991, p. 20). A big component of any new system should be devoted to preventative measures. Attention to basic life needs of children, such as the right to food, shelter and health care, should be a first step (Gwalla-Ogisi, 1991). The limited subsidized feeding schemes for children and primary health care for mothers and infants should be expanded. One way of achieving this, is to mobilize a strong lobby to advocate cutting back on military and defence spending in favour of feeding and caring for our children. Such services should reduce familial retardation, mild emotional disturbances and sensory handicaps caused by poor health, malnutrition and stress.

Major reform of the education system can be the driving force to ameliorate social problems related to AIDS, substance abuse, crime, and family disintegration. Provided that the (presently elusive) co-operation between state education and health departments can be forged, schools should be loci of health and human services (Kriegler, 1993). The embryo of this model is already in place in black schools in the existing Panels for Identification, Diagnosis and Assistance (the PIDA system) and in the primary health care provided on a six-weekly basis at certain schools. This projection of the school of the future has profound implications for community renewal, family preservation, and the nature of delivery systems for health, human services and education (PASA, 1991).

Concluding Remarks

Special educators in South Africa are in the position where we will have rapid and fundamental change either determined by choice, or simply thrust upon us by default. Perhaps due to a lack of understanding of the processes of change, as well as real or perceived vested interests, the education system and educators tend to resist change (Van der Westhuizen, 1993).

Changes of the nature and magnitude required in South Africa will not be easy to accomplish. There are only a handful of educators dabbling in the area of futurism and alternative future scenarios for education. Consequently policy change tends to be a purely top-down process, whereas optimally, it should comprise an interaction between top-down and bottom-up processes. The climate that will facilitate change will have to be carefully promoted (Gwalla-Ogisi, 1991).

The metaphor of root and branch to explain the nature of the changes that are necessary in order to make more schools effective for all pupils is illuminating (John Clark, in Ainscow, 1991). Many attempts to provide positive discrimination for pupils with special needs may be seen as branch changes. Their limited success can be explained by the fact that they have little or no impact upon the root culture of the schools in which they are introduced. Somehow, without losing sight of the complexity or the difficulties that face attempts at school reforms, we have to find ways of changing the root culture, including our schools' organization, curricula, methods of teaching and procedures of assessment (Ainscow, 1991).

The realities of our place and time must be borne in mind to allow for a diversity of models. A number of experimental projects is probably the most realistic strategy. Change should not be seen as an either-or-issue. Efforts should rather be directed towards identifying the different lines or axes of change, and formative appraisal of trends in REI direction, continuously formulating the implications for administration, legislation and teacher training.

The questions raised by special education strike at the heart of our education system, raising moral and ethical issues regarding what and how we teach. Especially, the factors that impede or facilitate the accommodation of diversity in schools must be identified, e.g. organizational aspects, management style, building flow and usage, resource availability and utilization. Along with other forms of discrimination, such as racism and sexism, *handicapism* should be eradicated from schools, transforming them into institutions of collaborative problem-solving, where the full range of pupil diversity is accommodated in a *most enabling* and *most empowering*, as opposed to least *restrictive* environment.

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International Journal of Special Education
1994, Vol. 9, No. 1

SPECIAL EDUCATION IN GHANA: PROBLEMS AND PROSPECTS

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The beginnings of special education in Ghana date as far back as 1946 when the first school for the blind was established through the initiative of Presbyterian Missionaries. As the enrollment for the school increased, the government became interested not only in the education for the blind, but all handicapped children.

In 1959, a committee of experts chaired by Sir John Wilson, a blind scholar, and Director of the Commonwealth Society for the Blind was invited and charged with the responsibility of examining the needs of disabled individuals apart from determining their population in Ghana. The estimated number of handicapped individuals then was 148,323 permanently handicapped adults and 10,000 handicapped children who were below age 15 (Amoako, 1975). A number of recommendations were made by the committee. These included the following:

1. A national system of publicity and registration be carried out to determine the extent of the problem.

2. Special provision be made in schools for the blind and the deaf, but as far as possible, orthopedically handicapped children should be mainstreamed.

3. The disabled should be sufficiently rehabilitated as far as possible to enable them to be absorbed into the country's normal occupations, both in rural and urban areas, and that specialized segregated institutions should be encouraged only where no alternatives existed.

4. Eight rehabilitation units be established across the country (Korsah, 1986).

Upon submission of the report by the committee, the government started implementing some of the recommendations, for example, a scheme was initiated to provide rehabilitation to as many disabled persons as possible (Walker et al., 1986).

Table 1

Number of Hearing Impaired Children Receiving Educational Services, 1992-1993.

School	Boys	Girls	Total
State School for the Deaf	85	73	158
Volta School for the Deaf	78	44	122
Demonstration Scool for the Deaf, Mampong	106	78	122
Koforidua Unit School	52	42	94
Kibi Unit School	80	45	125
Cape Coast School for the Deaf	68	53	121
Sekondi School for the Deaf	71	50	121
Jamasi School for the Deaf	48	74	122
Bechem School for the Deaf	138	95	233
Wa School for the Deaf	46	35	81
Savelugu School for the Deaf	72	22	84
Sec. Tech. School for the Deaf	41	10	51
Total	785	613	1398

There are five schools which cater to 315 children with mental retardation. Two hundred and three (203) are boys and 112 are girls (refer to Table 2).

Table 2
Number of Developmentally Handicapped ChildrenReceiving Educational Services.

School	Boys	Girls	Total
Dzorwulu Special School	80	40	120
Garden City Special School	43	19	62
Psychiatry Hospital School	8	4	12
New Horizon Special School	30	24	54
Twin City Special School	42	25	67
Total	203	112	315*

Table 3
Number of Visually Impaired Individuals Receiving Educational Services, 1992-1993.

School	Boys	Girls	Total
Arkopong School for the Blind	106	59	165
Wa School for the Blind	65	33	98
Wenchi Sec. School	13	6	19
Okuapemman Sec. School	13	6	19
Wa Sec. School	10	-	10
Akropong PTC	3	-	3
U. C. C.	3	-	3
Legon	6	-	6
Total	219	104	323

Table 3 shows the number of visually impaired individuals receiving educational services. Two hundred and sixty-four (264) are receiving their education in two elementary schools. Three Secondary Schools cater for 31 students and nine students pursue various degree programmes in two of the country's Universities, and three more are being trained as teachers in one of the Training Colleges in the country. In all, there are 323 visually impaired persons receiving educational services. With the number, 219 are males and 104 are females.

Problems

Even though there has been some growth in the provision of educational facilities for the disabled since the first special school was established, it has not been without problems.

First, the existing facilities are inadequate for there are still a lot of handicapped children out there who are not receiving any services. Some of the existing facilities need renovations since they have not been maintained for a long time. There is also a lack of basic equipment and materials such as audiotapes, hearing aids, large print books, etc., needed to properly train the disabled to become independent.

Second, there is no specific special education legislation in place to ensure the right of the disabled in being provided with adequate education and training. The Education Act of 1961 which was promulgated soon after the country won her independence, made schooling compulsory for every child of school-going age, the handicapped child included. However, the negative attitude of the public, including policy makers, towards the disabled stemming from the traditional beliefs about exceptional individuals is still a problem. The general belief is that educating a disabled child is a waste of time and resources. Therefore, provisions made to cater for the educational needs of the disabled is woefully inadequate. The schools have had to depend on non-governmental organizations and churches to virtually survive.

Third, special education services are provided for a few children whose handicapping conditions are easy to identify, that is the deaf, blind and the severely retarded (Walker et al., 1986). As a matter of fact, in Ghana special education is equated with deafness, blindness, and severe retardation. The mildly handicapped, i.e., those with learning disabilities, emotional behaviour problems are mostly enrolled in regular schools and they do not receive any expert help. As a result they are not able to cope with school work and are usually branded as lazy and stupid by their teachers. Most of them end up dropping out of school.

Fourth, early identification and early childhood intervention programmes are virtually non-existent in the country. The importance of early screening and identification of disabilities in children cannot be over emphasized, for through the development of early intervention programmes, several handicapping conditions have been eith been prevented, eradicated or minimized (Kysela & Marfo, 1983; Kysela & Marfo, 1984; Dery, 1981).

Fifth, existing programmes available for visually impaired, hearing impaired and the mentally retarded are rigid in nature, in that they are not adapted to suit the individuals disability. Thus, the instructional strategy used for the deaf is also used for the partially hearing, etc.

Sixth, no statistical data on the prevalence of the various disabilities in Ghana are available to aid in proper planning for the disabled. The hospitals do not keep records on children born with handicapping conditions, neither does the census bureau have current information on the figure.

Other problems hampering the smooth growth of the field are:
- unavailability of suitable assessment materials and practices.
- lack of interdisciplinary approach in catering for the needs of the disabled
- shortage of qualified personnel
- lukewarm attitude of the personnel in the field
- lack of employment opportunities for the disabled
- unavailability of financial and other resources for the support of special education services
- lack of partnership between parents and professionals in planning and implementing programmes for the disabled.

Prospects

With all the problems outlined one would wonder whether there are any prospects for special education in Ghana. The answer to this question is yes, there is hope for a better tomorrow, for already there are signs of it.

Since 1987 Ghana has been pursuing an educational reform in relation to the structure and content of her educational system. The major aim of restructuring the educational system is to make education cost effective as well as produce graduates who can easily fit into the workforce. As a result, more areas of study have been introduced into the curriculum and every child, including the one with disabilities is not given the opportunity to pursue secondary and vocational education.

Also courses in special education have not been introduced into the teacher training programmes. This augurs well for the field because the large number of mildly handicapped children who drop out of school may be identified and helped in the mainstream.

Finally, a five-year development project for special education is being planned by a committee of experts in the field. This is a major break-through, for it is hoped that some of the problems that hinder the smooth growth of the field will be solved.

Conclusion

A lot needs to be done to make special education what it is supposed to be in Ghana. Personnel in the field, as well as parents of the handicapped, associations for and of the disabled need to be encouraged to continue the fight for the right of the handicapped in Ghana. For the success of the field elsewhere have not been achieved on a silver platter, but through the sweat of concerned citizens.

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International Journal of Special Education
1994, Vol. 9, No. 1

A NATIONAL SPECIAL HEALTH EDUCATION PROGRAMME FOR ADULTS WITH SEVERE AND MULTIPLE DISABILITIES

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In 1977, at its Thirtieth Annual Meeting, the World Health Assembly declared unanimously that its main social target of member governments should be the "attainment of all citizens of the world by the year 2000 of a level of health that will permit them to lead a social and productive life". Now known as 'Health for All by the Year 2000', this declaration set in motion a series of activities that have had a major impact on thinking about "primary health care".

Primary health care (PHC) is defined as follows:

> Essential health care based on practical, scientifically sound and socially acceptable methods and technologies made universally accessible to individuals and families in the community by means acceptable to them ... It is the first level of contact for individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process (WHO 1978).

The WHO *Health for All by the Year 2000* campaign was announced in 1979. It emphasized accessible and primary health care, and a social approach to prevention. Initially applied to (in the main) developing countries, the mid-eighties saw the developed world adopt the Health for All approach with renewed energy.

In 1986, two major initiatives revitalised international debate— the *Ottawa Charter* and the *Healthy Cities* projects. The latter was turned into a tangible programme of action by WHO, who saw it as a reasonable way to translate the principles of the WHO Ottawa Charter into reality.

Its goals were:

– community participation in decision making and

– collaboration between different sectors working towards equity in health status between different groups, and improved ecological management.

Theoretical Developments in Australia

Beginning with the Alma Ata Conference in 1978, the WHO initiated a worldwide campaign for improving health status. The outcome of Alma Ata was a declaration highlighting the need for primary health care. It emphasised the local, accessible, and social facets of health care. In the following year, the WHO announced its goal of *Health for All by the Year 2000*. Following from the values and goals of Alma Ata, this campaign had particular relevance to developing countries, and much of the early documentation of strategies and projects referred explicitly to such countries.

Australia's Response

Despite its third world focus, many in the developed world saw the relevance of the Alma Ata goals. The mid-seventies in Australia had seen a surge of community health programmes, but by the mid-1980's many of the ideals and initiatives of these times had fallen to financial cutbacks, and *fiscal crises*.

Innovative and practical ideas in health policy were scarce. In 1985, A Better Health Commission was appointed to enquire into the current health status of the Australian populations, and recommend national health goals, priorities and programs to achieve significant improvement in illness prevention and illness.

It was also to *have regard to... Australia's part in the WHO's 'Health for All by the Year 2000' initiative* (Better Health Commission, 1986, xii-xiii).

In 1985, the Commonwealth of Australia's Department of Health also produced a report entitled *Advancing Australia's Health* with a strong focus on goals and epidemiological targets. In the mid-Eighties the Australia Community Health Association became a key carrier of *Health for All (HFA)* culture in Australia. It explicitly adopted the *HFA* approach in its review of the Community Health Program in 1986.

Ultimately, the WHO terminology came into the official national agenda with a report titled *Health for All Australians* (1988). This report quoted the WHO *HFA* values of equity, community involvement, health promotion, intersectoral co-operation, primary health care, and ensuring the appropriateness of infrastructure to health goals.

> ... To guard is better than to heal,
>
> ... The shield is nobler than the spear ...

People with severe and multiple disabilities are not usually included in health promotional or preventive programmes. In general, the focus has been on the *disability itself*, not on the individual's health needs, nor on future health status.

Most health education resources have been devised for educating the general population, and the information and techniques are often unsuitable or unrealistic for those with severe chronic disability and life-long handicaps. Even health promotion campaigns targeting the community via the mass media are poorly communicated and thus poorly understood, particularly by people in restrictive and protected environments.

Historically, their health has not been their responsibility, since they have been *in care*, and *taken care of* by others. It has been the responsibility of the carers— mother, father, the family, the doctors, the nurses, the therapists, but particularly the primary carer who is close to everyday personal health issues. So, high care needs have resulted in dependency on others to have needs met, and their health decisions made for them. Self efficacy, internal `locus of control', self-control and self-management, self-determination etc are not concepts often considered. Always being *cared for* has led too often to the person becoming a *passive recipient of care*, little involved in the making of personal decisions about their own health, and poorly informed about the healthy choices that could be realistically available. In the mid-eighties, through our Community Living Programme at the Spastic Centre, we were becoming increasingly aware of the vulnerability of our residents and clients as they left either our nursing homes or their parental homes, to live in staff-supported homes in the community. Our IPP process and our social education programme — both tailored for meeting individual need — were identifying, time and time again, the special health education needs related to the person's lack of health knowledge, and inexperience in making informed health decisions about lifestyle.

Transition is always a time of change, a major life event of stress, but it was appearing to us that authorities with values of the counting house wanted us to *get it over with* as quickly as possible, without addressing the needs imposed by change. The clients themselves, their families, and many of us working in partnership with them, were very concerned at their leaving the *protection* of a health care institution without adequate health knowledge and decision-making skills. Clients were requesting information about their bodies, their disability and impairments, their abilities and health skills, their sexuality and sexual health, their food and nutrition, their ongoing therapy needs, their stress, and ways to cope with it, their exercise options and needs, their health choices and risks. They wanted to know so much. We realised, and it was not an easy realisation, that we had actively contributed to this dependency by fostering it at every turn, as from *cradle to grave* we said we would *look after* them. Now that *de-institutionalisation* was in full swing, people were frightened, faced not only with huge gaps in health knowledge and experience, but also huge gaps in appropriate community supports and services. There was a chasm between what they knew, and what they, as citizens with equal rights, should reasonably know about themselves, and about what they could do and expect as supports and resources in the community to enable them to lead as healthy a life as possible. Regardless of level or type of disability, all had rights of access to health information delivered to their level of skill and ability. All had rights to community health services to meet their health needs (Disability Services Act 1986). But, without the advantage of health knowledge and support, without the development of some basic health decision making skills, they would undoubtedly be *more* vulnerable to poor health, and run the risk of developing avoidable illness, further disability and handicap. Few experienced normal living environments, and normal health risk situations, yet they now were being expected to make realistic health decisions without being prepared for such tasks. In practical terms (quite apart from disability-related health problems that might occur), little attention had been given to the prospect that severely disabled persons were just as likely to develop the breast, bowel and lung cancer, diabetes, heart and vascular diseases, musculo-skeletal problems, and stress-related diseases of the so-called *normal* population. Sadly, many disabled people have been discovered to suffer from such diseases at a stage when little can be done to prevent their premature death. And this was happening at a time when the general public was being *actively* educated to prevent these diseases, by strong media campaigns and by health care professionals. Our emphasis on the major disability of cerebral palsy was diverting attention from all these other issues of health disease and risk. We saw cerebral palsy as our major concern and our main health efforts were to maintain what motor skills were existing, and to provide personal and nursing care to those who were medically fragile or who had high personal care and health needs. Much effort was expended to maintain the status quo— to keep the disabling condition static, to prevent it from worsening. But disability is never a static condition. Like health status, it will fluctuate through life. Ageing, lifestyle, stress, injury, exercise— one's total environment will, *must*, influence it, as well as the possible secondary disabilities related to it.

People like . . . Robert, Sue, Peter, David, Jenny . . . all these may have learnt to function effectively through therapy, or surgical or medical strategies, and they may indeed be functioning well, to the best of their abilities. But hypothetically, one could say that their inactivity, stress, weight, posture, nutrition, hygiene problems, etc., could increase risks of illness and poor health. Just like the rest of the population, they are at risk for developing all the diseases that everybody faces—related or not to the disability or to the lifestyle it imposes.

The equation was so uneven — so unbalanced! These people were not *sick* people: they were people with disabilities who may be *made* sick or unhealthy through lack of opportunity. Many of them have almost the same life chances of illness and disease as everyone else, but they are *without* the benefit of preventive health strategies, healthy choices and life experiences. If we could only ensure that they had access to the means for understanding what health broadly meant, and had the opportunities to practice healthy behaviour, we could perhaps balance the equation a little.

The World Health Organisation's *Health for All by the Year 2000* strategy, with its various primary health care and health promotion initiatives of the late Seventies and Eighties has made us far more health conscious as a nation; and our national and state governments had provided resources to promote health overall. There were strategies for the Aged, Women's Health, Healthy Lifestyle, *Quit (Smoking) for Life* campaigns, to name but a few. *None*, however, were specifically targeted to, or *getting through* to, our particular group. (The exception was an HIV/AIDS programme we developed at the Spastic Centre for Peer Support Education, funded by the national government and supported by WHO).

It was clear we simply had to develop our own strategy, once again, and we had to make it accessible in the widest sense of the word. Immediate measures were taken in our nursing home and supported community houses. Our trained nurses received further training to become *health educators* of both clients and staff, and our personal care attendants were taught to enable and encourage residents to take more responsibility for their own personal health care and medication needs. But we needed a far more specialised health educative strategy if we were to expect positive behavioural change and real health improvement. Research indicated the value of certain strategies, particularly those of social learning theory, and models of health education, like the *Precede* model (Laurence Green) which fitted well with the *positive outcome* goals we hoped to achieve. We collaborated with other organisations both nationally and overseas, particularly I.L.R.U., Houston USA, Sydney University Department of Public Health, and its Special Health Education Unit.

We received national funding in 1991 under the National Health Promotion Programme. Our brief was to devise an accessible health promotion resource of the highest calibre for people with disabilities, using the most up-to-date computer technology, resources and teaching techniques. Emphasis was to be placed on *health, wellness, prevention and community care*. The contents were to emphasise health knowledge, healthy choices, and to encourage as much as possible the skills of self-determination and decision-making. We were to optimise access to, and facilitate understanding of, health information and healthy practices.

Firstly, we developed a comprehensive Resource Manual, and then commenced adaptation of its content material into a variety of user-friendly formats. We wanted the programme to meet individual needs, to not be the other way around; just a programme *done* to them, like another treatment or therapy. We have used the most up-to-date computer technology available to us, with CD Rom data bases, video discs and adapted switches, as well as written interactive programmes, like self-correcting health quizzes, visual health crosswords, values clarification games plus health dilemma and decision-making activities. The core manual is titled *Wellness and Healthy Choices*, and it takes the user through from being a receiver of care, to being a consumer member of their community, and looking at (and even experiencing) the choices and decisions this entails. It's not gloom and doom though— it's fun, as learning should be!

Technical adaptations and special switches are devised for each individual. Some people have mouth pointers, some can manage keyboards, some have eye-control switches and *mouses*. Some cannot manage computers at all, so we explore together the best type of teaching method for them: there is *always* a way to learn, I am convinced of that.

Computer technology had zoomed ahead (and is still zooming), so we are fortunate indeed to have the expertise of very skilled advisors, disabled and non-disabled. A small company called *Ability Computer Services* (employing people with disabilities) transferred the written modules onto disc, and their creative computer whiz devised visual quizzes and adaptations based on the material, and introduced video clips on healthy lifestyle and choice. All available health education resources have been, and are being, researched and we continue to work closely with Sydney University Department of Public Health Health Education Unit, in developing programme material. The former organisation also guides us in our strategies, based on the philosophies and principles of prevention, self-determination and health education. Our National Health strategies continue to set good guidelines based on WHO *Health For All by the Year 2000* principles of community health.

The modules are described in greater depth in the Appendix. It must also be mentioned that the national funding body has been extremely patient with the time extensions our programme has required, and is still requiring, due to its breadth of needs, and its constraints.

Initial evaluation in September 1991, and the process evaluation of September 1992, has shown the programme has increased health knowledge of participants by an average of 76%, and increased community access to health services by 64%. More comprehensive findings will be available in September 1993, and are designed to measure changes that have occurred in health-related behaviours.

Another important achievement of the programme has been increased collaboration between the community service providers and the Spastic Centre itself, whilst client transition (if I may call it that) is happening. Information inter-exchange, networking and practical training in collaborative and transdisciplinary skills has helped greatly in ensuring a more co-operative, informed and co-ordinating health service for our clients. Expertise, particularly therapy expertise, of a highly specific neurological disorder of movement is now shared, which is how it should be. Many families and many of the community service providors —community health, medical, allied health, home care service providers — remain actively involved with the *Health Isn't Handicapped* Programme as they work with their clients.

The links in the chain have now been strengthened in what was previously a very fragile community health structure for some people with disabilities and their families.

Now, as well as having an estimated 15% of its population with disabilities (mild;moderate; severe; multiple), Australia is also a multicultural society. Whilst the majority of Australians speak English and come from Anglo-Celtic backgrounds, over one hundred different languages, not including a considerable number of Aboriginal dialects, are spoken. Immigrant Australians have been drawn from a wide range of cultural backgrounds, and there is a huge complexity of special education needs, including those of special health education. The issue, therefore, of equity of access is of great concern to us. With the *Health Isn't Handicapped* Programme, we are presently collaborating with representatives of cultural groups who will themselves adapt the Programme for use by their disabled members.

But the concerns of these groups regarding equality of access are second to those of the original indigenous inhabitants of Australia, the Aboriginal people and the Torres Strait Islanders. Their education and health status is very poor. Since European settlement in their country in 1788, these people have suffered greatly in many ways. Australian now has an estimated 300 000 Aboriginal people, or 1.4% of the total population of nearly 17 million. For both Aboriginal men and women, life expectancy is twenty years less than for non-Aboriginal people. The infant mortality rate is three times larger for the Aboriginal child. These are not statistics to make us proud.

This year, the International Year of Indigenous Persons, has caused many of us to look closely at our country's record, and particularly at the special education programmes available to our indigenous peoples, and we have found them wanting. Too often they are either non-existent, racist, or imposed without Aboriginal involvement.

APPENDIX I

Definition of Models of Service

[1] *Multi-Disciplinary Team Approach*

Professionals with expertise in different disciplines examine and work with the person individually. Professionals within the multidisciplinary approach still tend to work in isolation from other professionals to evaluate and serve their clients. This approach was designed to meet the needs of patients within medical settings (Hart 1977) whose problems are typically isolated to one particular domain.

[2] *Interdisciplinary Team Approach*

This model shares a major feature of the multidisciplinary approach: initial evaluations are performed indirectly by each professional (Hart 1977; McCormack and Goldman, 1979). It differs, however, in assigning a *case* manager, and in establishing formal communication channels to avoid fragmentation of services. Programme decisions are made by group consensus, but implementation remains specific to each discipline. That is, whilst programme planning is more collaborative, programme implementation is still isolated.

Major Problem of [1] and [2]— Their common reliance on what is called an :isolated therapy model", referring to the delivery of services *outside* of the settings in which the person is expected to perform the skills that are being trained (i.e. special therapy room). Skills are not often assessed in natural settings.

[3]*Transdisciplinary Team Approach*

Originally designed to serve *high risk* infants (Hutchinson, 1976), this approach is the one now usually embraced by services working with people with multiple disabilities. This model is characterised by a sharing or transferring of information and skills across traditional disciplinary boundaries. In contrast to models [1] and [2], this model incorporates an indirect model of service, whereby one or two people are primary facilitators of services and others are consultants. Important to this approach is an understanding that the *multiple* needs are inter-related. It addresses *who* provides services and *how* multiple needs can be met by virtually any team, member, given training and ongoing support.

[3](a) Integrated Therapy

This approach evolved to emphasise providing services within their functional contexts, and thus has become an important complement to transdisciplinary service provision.

[4]*Collaborative Teamwork*

To realise the benefits of the knowledge and skills of numerous disciplines, a *combination* of *transdisciplinary* and *integrated* therapy approaches has evolved— this is the *collaborative team* approach. It reflects the essential components of both *integrated therapy* and *transdisciplinary* approaches to service provision: team members who are not therapists are likely to provide the majority of motor and communication instruction on a daily basis. Therapists, however, *must* maintain direct hands-on involvement with clients on a *regular* basis.

Peer: A person who is an equal in social standing, rank, age, etc.
Cradle to grave: birth to death.

International Journal of Special Education
1994, Vol. 9, No. 1

QUALITY OF LIFE = EQUAL AND POSITIVE EDUCATION

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I am an aboriginal women, whom like most people in Australia society be they aboriginal or not, had no idea of the life styles, needs, resources or lack of resources which existed within our community to address the needs of the disabled and their families in our community that was until my youngest child became severely disabled (at 14 mths old).

When I really needed to know what was available to help assist my child to lead as high a quality lifestyle that she could possibly achieve despite her disabilities and the support we as a family would need to help her gain this standard, the resources needed were hard to find. And what was found was delivered in such a negative response that if we had not remained adamant and tied strongly to our convictions we would have long given up hope for our child. We can understand, why many others do give up on their disabled child, when very little or no hope at all is raised.

For me, as a parent of a disabled child *quality of life* is an *equal and positive educational outcome for her future*, which we as a family unit have strived to achieve and will continue to do so. But if the support mechanisms were in place the stress and inter relationships problems may not have occurred, the problems that my family have had to struggle to overcome and the emotional scars which now exist may never have been so.

Unfortunately the wider community: throughout all racial groups are not even nearly adequately educated on the issues and needs of the disabled in our community. From the various levels and ranges of disabilities which occur to accessing every day services that the non-disabled person in our community take for granted and how socially isolated the disabled have become in the non-disabled community, throughout all the so called *norms* in lifestyles the non-disabled finds hard to make into their own reality, due to the lack of educating the non-disabled. Ignorance has developed and fear and discrimination ultimately raises its ugly head. For the aboriginal disabled person in Australian communities, their disability problems are unfortunately doubled, as they must also face the fact that they will face racial discrimination as well as discrimination towards their disabled status.

With the lowest socioeconomic status, poor education and health status of aboriginal people, the disabled aboriginal persons needs being meet in any means is greater struggle than the non-disabled in aboriginal communities throughout Australia.

Many aboriginal students, due to IQ tests, were classed as being disabled and labelled as being *mildly retarded* and in turn placed into special *AO* classes. It was regular occurrence for aboriginal students to be found to have behavioural problems within these classes as they should not have been placed in such classes, it was not that the child was *mildly retarded* in any way. It was a case that both these IQ tests and teaching methods were culturally irrelevant in regards to aboriginal children.

Education in Australia has never been orientated towards aboriginal teaching styles, which is very much a hands on system within aboriginal communities where it has been a case of showing is better than telling and where story telling is very interactive and relevant to the lifestyle. Far removed from that of the non-aboriginal *mainstream* system of education, which does not evolve around life itself.

Prior to 1972 education was not compulsory legally for aboriginal children and if they did attend mainstream schools, the principal could at his or her own discretion or upon complaint of a non-aboriginal parent expel all aboriginal students attending that school. Therefore many aboriginal people do not have a mainstream education level and many that do, have had many negative learning experiences and it has become wide spread throughout aboriginal communities to have an apathetic view towards the education system and many also are apprehensive and even fearful when approaching schools on behalf of their own children.

The above is a broad picture for the non-disabled aboriginal person in regards to education and its becomes an even more negative situation for the disabled aboriginal person in regards to special education when the parents of a disabled child are rarely involved in decisions regarding their childs education needs and are never given the opportunity to have a choice and cultural needs are not even considered.

With so many issues being faced within education in regards to aboriginal communities, special education has taken a *back seat* and has only recently become more apparent on the aboriginal education agenda.

Unfortunately, like all the educational issues we are facing, special education will take a long time to be acted effectively upon, although we are aware of the need to address this very important issues, there are too many issues and so very limited resources to effectively address them all at once.

Aboriginal people in Australia are the most highly researched group of people in Australia but while the same sociological factors and negative outcomes have again and again been highlighted. Recommendations may have been made in relation to drug and alcohol abuse, fetal alcohol syndrome, poor nutrition and hygiene factors, sexually transmitted disease, hepatitis b, measles, otitis media and cataracts. The reality remains that the strategies needed to develop and implement positive, effective and culturally relevant services for disabled aboriginal people, their families and communities have not been appropriately addressed. If special education is to move into *mainstream* education when neither the needs of the disabled or non-disabled aboriginal person, have been adequately addressed then the individual special education programs for the individual disabled aboriginal student to meet with these cultural needs must be clearly defined and consultation including the aboriginal disabled student his/her parent/guardian and community in the development and continual assessment of their individual special educational plan are paramount.

The community should be involved as an extension as the community functions generally as a whole and on extended family basis. The community will need to be able to develop and implement the appropriate support services within their community if they are going to be able to offer their disabled aboriginal community members the opportunity to as high a quality of life that is within their ability to achieve, particularly if the global community is to continue to place, emphasis on the *normal* community reaccepting the disabled by offering the opportunities to do so.

The need to be part of and accepted by the wider community is the ideal but the lack of resources and continued *tunnel vision* attitudes of the *normal* community may cause insurmountable hurdles being placed before the disabled.

Within aboriginal communities, despite our disadvantaged situation in regards to the wider non-aboriginal community, we do have a greater advantage, in that our projects and services are totally community developed, implemented and run and are shown to be effective. Although more often than not the projects are short lived due to the lack of continued funding. We are an economically dependent people due to our historical past and the introduction of European lifestyle and standards in many regions, including both urban and traditional lifestyles our success have occurred because our services are developed to meet with the individual needs of a client. The client tell us what they want and how they want the service delivered to them. Information and upgraded government policy are given to our people and explained in plain English and the growing cultural exchange meetings that we have been actively involved in within our own community with *mainstream* services providers about aboriginal cultural and needs is taking effect, with the government and other funding bodies becoming more increasingly aware if how their policies have not in the past assisted aboriginal communities to develop community based services, as their policies are based on the *non-aboriginal* community and are heavily reliant upon volunteers whom are predominantly from the middle class white Australian population. Aboriginal communities do not have middle class and have very little or no fund raising capacity and such policies as existed have are negative in their effect on aboriginal community and addressing their needs.

In this the *year for the world's indigenous people*, it is appropriate that after the years of struggle and continual negotiations with government policy that we have now reached a stage of better communication and understanding and that the government is now listening to what we are saying our needs are, rather than the government telling us what it will do for our people, particularly within the field that I am currently employed, which is to put into places services for the frail aged and young disabled within my community. One quarter of our clients are younger disabled aboriginal people who without such services would be institutionalised and completely socially isolated and totally dependent upon their careers.

From the success of such programs that we have implemented in our community it is hoped that special education will develop upon a similar route for our community.

International Journal of Special Education
1994, Vol. 9, No. 1

THE EDUCATION OF CHILDREN WITH SPECIAL EDUCATIONAL NEEDS IN THE NEAR FUTURE IN SLOVENIA

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A decrease in the negative consequences of the present production-and - consumption oriented society and school with the emphasis being placed on quantity rather than quality, requires, among other things, a change in the system of values, the way of thinking, ideologies, concepts of education and training, as well as a reorientation of the entire society and school towards an intensive qualitative development. This can only be attained if the role of man will experience a gradual change from passive to active, creative, competent and more responsible at all levels and in all segments of society. Accordingly, an intensive education for all children, particularly those with special needs, requires, aside from a radical change of the role of pupils, teachers, programmes, instructional aids with technology, a different approach to diagnosing, classification, planning, instruction, and evaluation.

Never before has mankind been so rich as it is today, in that it is able to eliminate and overcome most of the diseases and problems, yet never so uncertain with regard to the objectives and values in education. What should be believed, what one will believe, what and how should we teach, and how should we bring up our children - these are the current issues throughout the world.

There are many who still believe that education is just training of the intellect, learning from books, and a matter of discipline to be imposed from outside. Hence a predominant orientation towards material knowledge and programme respectively. Others, however, are of the opinion that education is an internal strength growing from within, provided the necessary preconditions have been created.

According to the theory of contemporary education, the acquisition of knowledge is a result of interaction between the already existing disposition of future development inside the pupil himself and the stimuli to which he is exposed in his environment, with the purpose to develop a human being that will be well-proportioned and balanced in every respect (body, intellect, emotions, social skills, physical skills, health, character, and appropriate attitudes).

Sources and Factors of Changes in Society and School

1. The need for redirecting and transforming society and school from extensive toward intensive development.

The negative developmental consequences resulting from a predominantly extensive quantitative, production-consumption oriented development of society and school, call for their redirecting and transforming toward a more intensive qualitative development.

The most obvious general signs of the negative consequences of an extensive developmental orientation of mankind, or society, probably include the following ones:

- a shortage of raw materials and energy,
- technological and environmental pollution,
- a passive role of man - producing and spending,
- alienation and lack of awareness of dependence on environment,
- a crisis of moral values and too weakly developed relationships between people - a prevailing detached attitude towards the problems of others and a democracy placing too much emphasis on material values while neglecting spiritual ones.

The major negative consequences resulting from the prevailing trends in society towards extensive education could be regarded the following ones:

- overvaluation of material knowledge (programmes, subjects),
- orientation towards high performance without desired results
- overcrowded programmes, a demanding style of work,
- quick and predominantly frontal methods of teaching,
- didactic rigidity and uniformity,
- neglect of quality relationships between people,
- a more selective rather than developmental approach leading to the following negative consequences:
- a mania for testing knowledge only, trying to substitute the mania for testing intelligence
- a high dropout rate, drug abuse, aversion to school
- insufficiently developed differentiation and individualization
- a high delinquency rate
- a drop in knowledge in relation to test results
- a too low self-esteem
- increasing disrespect for the teachers by both the pupils and community (Gibbs, Jeanne, 1987, p.3).

Due to a shortage of raw materials and energy, as well as danger to man and environment, all the factors enumerated above assume a quite different role and import. Under an intensive orientation, it will be necessary to manufacture, from fewer materials and by using up less energy, all the desired products, by reducing environmental pollution at the same time. This can only be achieved if technological processes have been improved. These technological processes, however, can only be improved by developing purer and more rational technology. Similarly, a purer and more rational technology can only be developed by a more creative, more highly developed and ecologically conscious man, by means of a higher-quality knowledge, better relationships between people, better communication, and greater responsibility. An intensive development orientation of society and school preconditions and active and conscious man at all levels, therefore also in education.

The rapid changes in working processes, both in society and companies reflect themselves in business failures of companies, in unemployment, other attitudes and values, other viewpoints, other way of thinking and ideologies, all of which leads to the transformation and abandonment of the existing ideologies and political systems, to wars, disintegration of states, and to the emergence of new ideologies, states and international associations.

Man will have to master new technologies, or else he himself will be controlled by them; or, in other words, those who will control modern technologies will also control those who won't be able to do so.

Hence a very strong need for a change and transformation also in education in general and in particular in the education of children with special needs, towards a better exploitation of human potential, a balanced and optimum development, greater creativity, more adequate viewpoints and values, better relationships between people, and a more adequate evaluation in terms of developmental stimulation.

The above-stated development problems in society and school, on the one hand, call for a greater orientation towards democratization, pluralisation, multiculturalization, integration, differentiation and individualization, and on the other, for a more intense communication, the establishment of closer links, greater dependence, order, discipline, and responsibility.

2. New findings in education

To the above-described developmental trends in society we can also add some more recent findings in education which, from another viewpoint, confirm the above mentioned findings:

- the problems are varied and there are no common solutions to be applied to all of them, which results in the need for a development of differentiation and individualization
- a pupil learns by means of his own activity, provided the necessary conditions and the necessary stimulation are given, and no-one else can do it for him
- the educational process is equally important as the result of learning and teaching, which requires an active role of both the pupil and teacher
- a balanced orientation towards the children (towards good relationships and good teaching methods) and towards the programme, towards adequate and just-right performance; it should give better results

- basing oneself on positive assumptions, on what the child has and not on what he hasn't, i.e. not on disabilities, handicaps, and the like
- accentuating the most developed functional areas and positive behaviour
- all programmes and methods have a relative value
- the more the children with special educational needs are integrated, the better they will develop, provided the necessary conditions for the selected form of integrated education are fulfilled

3. Interactional concept of the causes of disabilities and integrational trends in the education of children with special needs

A disorder develops as a result of the interaction between the child with a deficiency (blindness, deafness, etc.) and the inadequate surroundings.

> A direct consequence of a deficiency is a gradually progressing deterioration of a child's social position, till his deficiency finally transforms itself into a social disturbance. Gradually, a reorganization of all the existing links to people and of all the elements that determine a person's position in society is established. Organic (inborn) causes don't act directly but indirectly through a gradual deterioration of the child's social position. All the organic and hereditary factors have to be psychologically explained, in order to identify and evaluate their true role in child development (Vigotski, 1987, p. 16).

It is obvious that blindness and deafness are physiological and not social conditions. In spite of this fact, however, teachers must concern themselves as much with physiological as with social consequences. Accordingly, it is not a question of blindness per se but rather a question of conflicts and consequences of blindness (or deafness) which develop in the course of integration into community life of a blind (or deaf) child. Much the same applies to a mentally retarded and otherwise handicapped child. It is our task to help such a child with a deficiency to integrate in life, to develop a compensation for his weakness by means of his rearranged social links. Also, according to Vigotski (19087, p. 45) the psyche of a child with a deficiency is getting shaped, primarily, not under the influence of his physical deficiency but rather under the influence of other social consequences which are a reaction to the child's deficiency, or weakness.

In social integration of children with special needs, therefore, the deficiencies themselves are not of such great importance as are the reactions of people to the deficiencies of these children. Hence it follows that a successful social integration, including educational, depends to a much greater extent on the environment into which the child with a deficiency should integrate than on the child with such a deficiency.

Briefly, the above described notion of the development of such disorders indicates clearly that the causes of the development of such disorders are also in a child's environment and that in most cases disorders in children wouldn't have developed if the environment hadn't exerted an inappropriate influence on them.

From the above it follows that it's not just the child that should be blamed for his disorder but also his environment, which is to mean that such a child can only be properly helped if adequate and timely help is given both to the child's environment (family, neighbourhood, school) and to the child himself by meeting his special needs.

Such a concept of children with special needs deviates from traditional medical, social, and special-school-related concepts of education based on disease, deviation and disorder, replacing them by educational, developmental - individualized, and integrated concepts based on aptitudes, ability, and development.

Integration is a two-way process going on inside the pupil and between the pupil and other people. Consequently we can talk of internal integration or intraintegration (integration of biological, mental, and social components) and of external or inter-integration (integration with other people, society, playmates), to which, in a way, also our educational integration belongs. Considering the views held by Vigotski, Piaget, Bruner, and some other experts, higher mental processes develop properly only under favourable cultural conditions and in suitable social environment respectively. It could be concluded that a rather poor internal integration by the majority of children with special needs is due to poorer external integration or, in other words, due to a poorer social environment, which is also evidenced in many studies by a correlation existing between socio-economic status and educational mental retardation (c = 0.70 and 0.63 in Sprinthall, 1990, p. 585).

The goal of an adequate social integration, to which, broadly speaking, also belongs educational integration, is a better internal integration or a better child development. And one of the most important goals of child development resp. internal integration is the best possible social integration, being the source of new stimulations for an even better child development. The group, the people (family, playmates, school, community) provide stimulation to the child resp. represent a source of food for the mind.

From such a didactically classified integration can be seen a connection between individualization and integration resp. socialization. The aim of individualization is optimum child development which also includes the best possible connection to other people - therefore also social integration. The aim of a real socialization, however, is always the development of society, which, in turn, can only be achieved through a proper development of an individual, i.e. through individualization.

We could say that individualization and integration (socialization) are two sides of the same phenomenon, just like giving for one and accepting for another and vice versa represents one and the same action for two people living together.

Of course, the above defined and derived conclusions are theoretically (rationally and morally) valid and feasible, but their realization is extremely demanding and would take a long time, as it requires great changes in the way of thinking and the valuation of the children with special needs in school and society, the attainment of which is only possible through an integrated, systematic, and planned activity extending over a longer period of time.

However, it can not be expected that at the present level of mental and material development all of the above stated ideas and conclusions could be realized at once, with all kinds and degrees of weakness and disorders of children, but there should be adopted a long-term mental orientation toward a gradual development of more integrated programmes and forms of education. In many places, the present spiritual and material level is probably more suitable for segregation than integration, although the paradigm of integration, coexistence and cooperation is a newly discovered idea, and this is the only possible paradigm of further development for the entire human race, which can make it possible for us to solve the problems of overpopulation, food shortage, energy shortage, shortage of raw materials, all forms of pollution, social differences, as well as the above-stated problems at school.

On the other hand, this doesn't mean that it is not necessary already today to gradually realize the possible and, in terms of development, urgently needed portion of the continuum of differentiated programmes. On the contrary, in its complexity as a process of development, integration demands great and almost unpredictable changes, both in society and individual. We should not be diverted by the first failures which can be expected under the present valuation practices and the prevailing mentality in school and society. Almost all changes that are worthwhile begin with failures. In time, however, if we persevere and look for better solutions and conditions, they become indispensable and we can't do without them any more.

Developmental Trends in Education of Children with Special Needs

The above-described changes in society and school are so radical that they interfere with the essential changes in the roles of the key factors involved in educational process (with the role of the child, the teacher, the programme, and the teaching aids with technology), as well as bringing about a gradual change of all the four functions of education (diagnosing, planning, organization with instruction, and evaluation). The above changes also affect the rest of the constituent parts of the concept of education, such as: goals, approaches, and strategies.

With regard to educational results, the child, the pupil, the student will be the most important factor of educational process at school. On the second place will be the teacher, on the third the programme, and on the fourth the aids with technology. The value of the programme will be relative and dependent on the respective role of pupil and teacher rather than vice versa, although today we quite often behave as the programme were the most important of all. A good teacher may have good lessons even if the programme is not the best, whereas a bad teacher won't teach well even if the programme is good. However, it is true that a good programme helps both good and bad teacher. If half the time currently spent on concerning ourselves with programmes were dedicated to pupils and teachers, our education would be greatly more effective.

1 Diagnosing

The knowledge that education is a result of the interaction between the child and his learning environment, as well as the inadequacy of current diagnosing practices, require that a child's learning environment (the school, family, classroom, teaching methods, atmosphere, valuation standards, etc.), should be diagnosed first, while the pupil should be diagnosed after that, in the process itself. This would gradually lead to stop searching for causes of troubles only in a child with a special need, also ending repeated accusations and labelling of such a child.

Classical diagnosing, which is oriented to disease, disorder and deficiency, will be paid less and less attention (validity problem), while an increasing emphasis will be placed on health, skills, development, programming, methods of instruction, and evaluation. It is necessary to gradually introduce process diagnosing, guiding into programmes instead of classifying them into categories of disorder.

2. Guidance into programmes instead of classification into categories of disorder

Long ago, research showed that our classification practice are outdated, since they rest on inadequate and partial diagnosing basing themselves chiefly on intelligence tests in which, according to Maynard Raynold, numerous shortcomings were determined, such as:

> there is no sharp discontinuity in mental abilities between people with IQ of 79 and 81 or 49 and 51
>
> the test scores are also subject to the limitation of examiner influence and culture bias
>
> the tests are not assessing the complete range of child's functioning
>
> the tests themselves are virtually useless for making educational decisions with regard to placement
>
> we should spend far less time in predicting how children with special needs may perform in "traditional" classroom as result of an IQ score. Instead we should develop more effective instructional procedures.
>
> Special education should talk less about dysfunctions, low IQ, deficits, impairments and disabilities. Instead school offerings should be differentiated sufficiently so that all children receive the help to develop optimally (Sprinthall, 1990, p. 579).
>
> The grouping of children by means of IQ scores is a false pedagogic ideal and is in contradiction with the laws of development of higher mental functions and with the suppositions according to which mental functions in children in general, particularly in children with special needs, are variegated and dynamic (L. Vigotski, 1987, p. 102).

It is obvious that classification based on negative characteristics of children is unreliable, yet all the same it is with great difficulty that we are abandoning this practice. It has been proved that we can't rely on what a child has not but on what he has, what exists. It's not so much the disorder that counts in education but rather how a child develops.

Instead of classifying children into categories we shall gradually implement a system of guiding them into most appropriate programmes, for one year at a time only. In order to be able to properly guide children with special needs, we need a continuum of programmes, ranging from the least to the most demanding, from the least to the most integrated, from asylum to ordinary class.

For a deeper and wider understanding of the problem, it is necessary to combine the illustration of the continuum of the programmes with the degree of integration resp. segregation of the programmes within the continuum. Let us have a look at one possible classification of twelve programmes and forms into which children with special needs could be guided, with the continuum of the programmes, along with the degree of integration resp. segregation of the programmes ranging from the highest to the lowest, being illustrated at the same time. From the dimension of the continuum of the programmes it can be seen that the terms integration and segregation describe the same phenomenon, from a different viewpoint only. Hence it follows that when talking of integration we simultaneously also talk of segregation, or, in our case, of the degree of integration and segregation of the programmes.

Table 1
Degree of Integration and Segregation

Degree of integration	Programme - organizational form	Degree of segregation
12	RC*, with no additional help being offered	1
11	RC, with normal additional help offered (classroom teacher)	2
10	RC, with normal additional help being offered in the classroom (classroom teacher + defectologist)	3
9	RC, with additional help being offered outside the classroom (defectologist, psychologist, social worker)	4
8	RC, with special help offered in and outside the classroom (defectologist, psychologist, social worker)	5
7	RC, with periodical separation from the classroom for certain topics and subjects (c. teacher, defectol., soc. worker)	6
6	Special class in RES**, KG*** (defectologist, psychologist, social worker)	7
5	SS**** (defectol., psychol., soc. worker)	8
4	Residential home, reformatory school (with child going home for weekends only)	9
3	Hospitals and health resorts (chronically diseased children, not able to go home)	10
2	Special institutions (children not able to go home, only visits by parents possible)	11
1	Prisons, asylums (high degree of disturbance, with ties to outside world broken off)	12

Key:			
	*	RC	- regular class
	**	RES	- regular elementary (8-year) school
	***	KG	- kindergarten
	****	SS	- special school

The realization that integration and segregation are two ends of the same phenomenon indicates that opposing views held by various experts concerning integration and segregation rest, in most cases, on a different understanding of the essence and that a possible answer to the problems of education and instruction of children with special needs is the implementation of a continuum of programmes ranging from the least to the most demanding ones (this was already proposed before by other authors).

Under this classification of programmes, there is no need for a child to be at first negatively designated, *labelled*, as having such and such and so and so many disorders, that he is less capable, behaviourally problematic, and to assign him permanently, on the basis of such a *rich* negative designation (*good professional justification*) more segregated than integrated school or institution, thus categorizing him as a second-class citizen.

If experts should determine, by means of a comprehensive process-based diagnosing of a child's environment and the child himself, that it would be best for the child to go to special school, he can be proposed to go there for one year, whereupon a repeated evaluation and decision-making as to whether he should stay there or be moved to some other programme will be carried out. The intention of such an approach is not to abolish special schools but to ensure an optimum development for each child with special needs, for special schools will exist for a long time yet as highly specialized schools for the most disturbed children, provided they will follow the trends in education of children with special needs in kindergartens, regular elementary and secondary schools. Thus, the main criterion in guidance should not be either a segregarional or integrational philosophy but the appropriateness of the programme in terms of developmental needs and potential of a particular child, therefore the child as such and the level of his developmental progress.

A greater accuracy in guiding into the most appropriate programmes could be attained by transforming the diagnoses of the child's environment and his characteristics into a global individual programme for a certain child and by finding, on this basis, a programme in the continuum of the programmes that is most congruent with the child's individual programme.

An adequate guidance into programmes requires the development of various programmes and models of internal differentiation in kindergartens, elementary and special schools (programmes of grade seven through grade eleven of integration). The necessary programmes of external differentiation have been developed from grade one through grade six of integration. In these, it is necessary to develop quality.

3. Programming

In programming, the need for an increased direct planning, for measurable, balanced, differentiated and individualized programmes, for more adequate approaches, better organization and instructional aids is becoming increasingly apparent. It is being demanded that an individualized programme for each child with special needs who can't adequately follow the lessons be made.

4. Organization and Instruction

As for instruction, there should be less talk about of dysfunctions, low IQs, deficits, handicaps, and disabilities. Instead, along with schools, special education should develop such forms of internal differentiation of work that will make it possible for the pupils to share the most adequate help necessary for their maximum development.

In view of the fact that children with special needs account for about 20 - 25% of the elementary school population and that only 2.5% of them are given adequate treatment in special institutions, and also considering the fact that about 17.5 to 22.5% of them are included in regular elementary school without the provision of adequate forms of help presp. without the prerequisites of successive internal integration being met, we can certainly say that there is urgent need for the development of internal differentiation in kindergarten and elementary school.

In terms of methodology, the education will have to be increasingly directed toward a democratic approach, toward an individualizational and integrational concept of education, as well as toward all the three models of instruction and learning: transmissive, inductive-and-research-based, and interpersonal.

5. Evaluation

As for evaluation, there should be an evaluation based on the programmes (both collective and individualized), child progress, quality of programme execution, quality of instructional aides, conditions of conducting education of children with special needs. As soon as possible, it will be necessary to implement descriptive grading of pupils, at least at the lower level (grades 1 - 4) of elementary school, but gradually also in upper grades.

The implementation of adequate education for children with special needs in kindergartens and elementary schools as well as an improvement in the quality of work in elementary school with adapted programme will benefit all children with special needs in all schools and all other pupils and teachers in elementary school, as well as the whole society. Without solving the fundamental problems of the population of children with special needs in kindergarten and elementary school, neither of the two will be able to make an adequate developmental move forward.

For this reason, the solutions for this population of children will have great transfer effects for the whole elementary school, the special school, as well as the kindergarten.

6. The most fundamental preconditions for the realization of the changes described

The realization of the changes defined above requires a gradual provision of the below enumerated and other conditions:

- an adequate definition of the roles of individual factors of the learning and teaching process with regard to set goals;
- a change of the programme of the study of special pedagogy (greater integrity and balance), adequate relation between theory and practice, between science and art, between medicine, social welfare and education.
- adequately trained staff, special teachers, for work in elementary school and in special forms of education, for new diagnosing, planning, instruction, and evaluation.
- a gradual integration of the programme of study for elementary teachers and of the programme of special teachers to such a degree as would be most suitable with regard to developmental needs of children and the problems of schools.
- development of positive attitudes toward children with special needs during the time of study in all fields of study, but also in kindergartens and elementary schools.
- employing of special teachers, to work in kindergartens and elementary schools as operatives in developing various kinds of internal differentiation and individualization.

an adequate number of children in a group

a readiness for materialization of the necessary changes at all levels (faculty, ministry, office of education, and schools)

the necessary funds and other material means

elaboration and adoption of a new concept of education for pupils with special needs and for special teachers, along with a gradual implementation.

The above perspective of development of special education for the majority of children with special needs in elementary school is in essence defined by common consent in this year's expert supporting documents for the coming Compulsory Education Act, and we are assessing that it will take some 10 to 15 years for it to be realized.

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International Journal of Special Education
1994,Vol. 9, No. 1

SPECIAL EDUCATION IN TANZANIA: A CRITICAL ANALYSIS OF SPECIAL EDUCATION SERVICES

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This paper presents a description and critique of special education services in primary schools of Tanzania. It provides a historical background of Tanzania's special education services and outlines the theory underlying special education development in the country. The paper looks into availability of schools, enrolment of children with various disabilities, teacher training, and special equipment. It also identifies various successes and failures of the special education system that are attributed to social, political, and economic forces within and outside the country. Lastly, the paper provides solutions to the identified problems .

The United Republic of Tanzania, has a population of about 23 million people with approximately 2.3 million or 10% persons with various disabilities (Faculty of Education, 1989). The country's special education policy is integration that is, placing and educating children with disabilities in educational programs serving children with and without disabilities.

As with other developing countries, special education in Tanzania is a recent phenomenon. Nchimbi (1981) explains that special education was introduced in Tanzania by philanthropic organizations and religious groups whose focus was educating individuals with visual impairments. Their motive was *fulfilling God's law of love and charity to the poor*. Tanzania's first school for children with disabilities was started by the Christophel Blinden Mission in 1950, (Buigiri Special School for the Blind and Visually Impaired Students). In 1962, The Swedish Missionary Church opened another school for the visually impaired (Eklindh & Nchimbi, 1989). In the same year, the Roman Catholic Church opened and operated a school for the deaf and the Salvation Army established a school for the physically handicapped (Nchimbi, 1981).

The Tanzanian government became involved in special education after the country's independence in 1961. To date there are 73 schools. Within some schools there are units that are classrooms serving children with disabilities in regular schools. That is a very big step ahead in special education development. However, given the country's population, one would expect a higher number of schools and special services for children with disabilities than the current one. To the contrary, there are many students requiring special education services and are not being provided with the services. Social problems affecting the development of special education will be discussed.

Kisanji (1979) argues that there are many students in regular primary schools in Tanzania with disabilities ranging from mild to severe. These students are sometimes labeled as *dull*, *stupid*, or *backward*. The researcher found that 39 out of 1164 children in the primary school classrooms he observed had behavioral and emotional disturbance, 11 had learning difficulties, and 4 suffered from poor health. Such students were in regular classrooms and Kisanji (1979) observed no educational services for them. He states that these children were neglected in the teaching and learning activities because teachers were not prepared to handle them in classrooms. The Faculty of Education (1989) indicated that besides the more than 1.06 million children aged 0 - 15 years with severe disabilities, there are unknown numbers of gifted and talented children and young people. It is not wrong therefore, to say that Tanzania caters to a very small proportion of the population of its children who deviate from the norm. Students with disabilities and exceptionalities need special education services for their future success.

Theory Underlying the Development of Special Education in Tanzania

Special education in Tanzania has progressed through several predictable stages as a result of social, political, and economic forces from within and outside the country. It may be argued that the development of special education in Tanzania is following the development stage's hypothesis. This hypothesis, according to Brouillette (1992), suggests that a society creates structural stages conducive to the programs of special education. There is an interactive combination of social, economic, and political factors for developing comprehensive special education services. In Tanzanian, each of the following events has positively affected the development of special education services: the nationalization of schools after independence in 1961, the introduction of the Arusha Declaration in 1967, the declaration of Universal Primary Education (UPE) in 1978, and the increased awareness achieved from the 1982 International Year of Disabled People (IYDP).

The Development of Special Services for Children with Disabilities

Right after independence in 1961, there was an increase in the number of primary schools for children with disabilities. Three more schools opened between 1962 and 1963 (Nchimbi, 1981). Also the 1967 Arusha Declaration, the policy on equality and self reliance, led to the opening of three schools for students with disabilities (Ministry of Education and Culture, 1992). Further, after the 1974 declaration of Universal Primary Education (UPE), Tanzania witnessed a number of openings of schools for the disabled between 1974-1978. The International Year of the Disabled Persons in 1982 gave rise to more schools, especially for students with mental retardation (Ministry of Education and Culture, 1992). Should the development of special education depend on such forces? Tanzania should have developed long term special education plans.

Number of Schools for Students With Disabilities

The number of schools for students with disabilities has risen from one in 1950 to a total of 73 schools and integrated units (Ministry of Education and Culture, 1992). There are also itinerary services (travelling teachers) for students with disabilities whereby itinerary teachers provide services to students in schools and at times in their homes. Table 1 shows the number of schools serving students with disabilities. It is clear from Table 1 that children with visual impairment have the largest number of schools followed by those with mental retardation, physical disabilities, and hearing impairment. One may not be wrong, therefore, to say that Tanzania caters more for students under the traditional categories of disabilities i.e. visual (mainly total blindness), hearing, and physical disability. There are no services for children with behavioral disorders and those who are gifted and talented. Neither are there schools or services for children with learning disabilities. Children with low vision such as albinos are not considered eligible for special education. In fact, sometimes partially sighted students are forced to learn Braille and/or attend schools for the visually handicapped instead of being taught to use their residual vision or through the use of large print. In this way, the system may be *teaching* some partially sighted students to become blind.

Further, there are no services for at-risk children. Heward and Orlansky (1992) define at-risk children as those who are not currently identified as handicapped but are considered to have a greater-than-usual chance of developing a handicap. The situation in Tanzania is similar to what happened in the United States and other developed countries in the past whereas these countries presently serve people with various disabilities. In the United States children with visual impairment were the first group to be served followed by the deaf. It was only in the early seventies that children with Mental Retardation and Learning Disabilities received attention/services. The United State might be one of the good examples for Tanzania to emulate and modify some of the special education services to suit the Tanzanian children, taking into consideration the country's social, political, economic, and cultural aspects.

Table 1

Number of Primary Special Classes/ Units Serving Children with Disabilities.

Type of Impairment	Number of Schools/Units
Visual Impairment	30
Hearing Impairment	9
Physical Impairment	14
Mental Retardation	29
Speech/Language problems	0
Emotional / behavioral problems	0
Multiply handicapped	0
Gifted and Talented**	0
Low Vision**	0
Learning Disability**	0
At risk children**	0
Total	73

Source: Modified from Kisanji (1993) and Ministry of Education (1992) Enrolment

Table 2

Estimated Number of People with Disabilities in Tanzania.

Leprosy	170,000
Physical Handicap	136,000
Mental Retardation	136,000
Blind and Visual Handicap	79,000
Deaf and Hearing Impairment	51,000
Total	572,000

Source : Nchimbi (1981)

A total of 2,157 students are enrolled in the 73 schools for children with special needs (Ministry of Education and Culture, 1992). However, as Table I shows, this is only a small percentage of the estimated number of people with disabilities in Tanzania as indicated in Table 2. It can be concluded from Table 2 that there is a large disparity between enrolment and the number of disabled people. According to the estimate, the total number of people with disabilities account for 3.3% of the whole population, hence annual increase of 6,000 to 7,000 people with disabilities. Looking at the percentage one would expect the country to have highest number of schools for the physically handicapped students, followed by schools for children with mental retardation, then children with visual impairment and lastly, for those with hearing impairment.

While it can be clearly seen that there has been a great improvement in services and enrolment of children with disabilities since 1950, and that there has been a great move toward integration, there is still low enrolment rate of children with disabilities compared to that of non handicapped children. In 1989 it was reported that only 1% of the country's 160, 000 school age disabled children were enrolled in various schools for children with disabilities (Daily News, 1989).

Kisanji (1979) found the incidence of handicapped children in Tanzania to be 0.88 per 1000 for those with mental retardation, 1.76 for cerebral palsy, and poor health, 3.97 for maladjustment, 4.41 for hearing impairment, and 5.74 for learning difficulties. These figures yield a total of 19.43 children with handicaps in every 1,000 school population. One would naturally expect students with higher incidence of disabilities to have higher enrolment compared to those with lower incidence. However, that has not been the case. Table III indicates imbalance in terms of children under special education programs. For example, there is higher enrolment of children with visual impairment than those with developmental disabilities despite the fact that the estimation of the former's incidence is lower than that of the children with mental retardation. The reason for the lower enrolment of children with disabilities in general and particularly those with higher incidence might be due to overprotection of children with disabilities in the country. Kisanji (1979) had indicated that the hiding of handicapped children by their parents and refusal to send them to hospitals or schools was common in Tanzania. The *Daily News* reporter (1989) attributed the low enrolment to the unwillingness of parents to send their children to schools far away from home.

Table 3

Number of Students and Teachers in Tanzanian Primary Schools.

	Gender			
Schools	Girls	Boys	Specialized Teachers	Specialized Teachers
Integrated Units	209	297	32	55
Itinerary Programs	33	57	–	–
Special Schools				
Blind	195	273	64	50
Speech	73	115	20	18
Hearing Impaired	292	432	71	10
Mental Retardation	69	113	12	12

Source: Ministry of Education and Culture (1992).

Enrolment by Gender

Table 3 shows the enrolment in integrated and special schools as well as units in terms of gender and type of disabilities. One can easily notice the low enrolment of girls compared to boys. Can it be concluded that parents do not value girls' education? Mosha (1992) argued that there is equal access to education opportunities for all children in Tanzania regardless of their physical, intellectual or emotional disabilities. Where is equal access in education in terms of gender? Can it also be concluded that Tanzania has more boys with disabilities than girls? Such facts are not yet established in the country. The low enrolment of girls in schools should, therefore, not be taken to mean that there is a smaller percentage of girls with disabilities. There might be cases of overprotection of girls by their parents, in particular, their mothers. Parental attitudes about handicapped children might include some girls with handicaps being kept at home, doing household chores where they can, or might be treated like the sick, to be looked after, or viewed as liabilities. Research needs to be carried out so as to look into parents' attitude toward girls' with disabilities.

The author's observation is that there are more schools and units in urban and/or easily accessible areas than in rural areas (Ministry of Education and Culture, 1992). One would logically think that there would be more schools for children with disabilities in rural areas due to the fact that more than 90% people in Tanzania live in villages or rural areas (Ministry of Education and Culture, 1980) . The concentration of special education schools in urban or more affluent areas might be due to problems in rural areas such as lack of public transportation in particular and underdevelopment of infrastructure in general. Another reason might be negative attitude towards people with disabilities (See Table IV). Possi (1988) found that many people held negative attitudes toward albinos. Some people believed the cause of albinism to be due to angering ancestral spirits, reincarnation, or even bad omen. The beliefs might lead to either killing of albino children or *handling them with care* to avoid the anger of ancestral spirits or punishment. Such *handling with care* might lead to overprotection. Kisanji's (1993) literature survey clearly indicates negative family and community actions towards the handicapped ranging from hiding, rejection, overprotection, and even denying formal education to children with mental disability, albinos, and lepers. Table 4 describes some people's beliefs regarding persons with disabilities. It is obvious that if some people in the society harbor such negative attitudes toward the education of the handicapped, some children might remain uneducated. If such attitudes are not addressed by educational institutions so that attitudinal change occurs, the goal of compulsory primary education in Tanzania will not be realized.

Special Education Teachers in Tanzania

The Ministry of Education and Culture has set the teacher student ratio to be 1: 5 in integrated schools and 1:10 in special schools. However, the ratio has not been realized because of lack of trained teachers. Table 3 shows that there are few trained special education teachers, for example, there are 317 fewer teachers than the required number of teachers in schools for visually handicapped (Ministry of Education and Culture, 1992). However, whether or not there is an equivalent shortage of teachers for other disabilities has not been indicated. The data show that there are more non specialized teachers than specialized ones in schools for children with disabilities. The non specialized teachers may face problems in handling children with disabilities.

Table 4

Range of Folk Beliefs Regarding Disabilities in Africa.

Disability	Stated Causes	Family Community action	Child rearing practices	Educational training	Vocational options
Visual	Witchcraft; curse from God/gods Anger of ancestral spirits, diseases, accidents	Let live	Over-protection, hiding, rejection sent to grandparents	Traditional informal, education school dangerous	Weaving basketry playing musical instruments
Hearing impairment	Curse from God/gods Anger of ancestral spirits Witchcraft Genetic	Let live	Overprotection hiding, rejection normal, rough work because strong	Difficult to teach but primary school only, training in local activities	Mechanical and physical labor
Severe Physical Disability	Curse from God/gods Bad omen Anger of ancestors Witchcraft Reincarnation	Killed/ let live	Ambiguous status, Custodial care, God appeasing rituals with application of talismans, overprotection rejection	No education	None
	Supernatural being	Let live	Ceremonies for the supernatural being	Traditional/oral informal education	None
Lepers	Curse from God/gods Witchcraft infectious disease	Isolated None	None None	None N/A	

Table 5 continued:

Disability	Stated Causes	Family Community action	Child rearing practices	Educational training	Vocational options
Mental Handicap	Curse from God/Gods Bad omen Reincarnation	Killed/ let live	Custodial care overprotection rejection sent to grandparents	No formal education (mildly handicapped go to school before noticed)	None
Albinos	Bad Omen Reincarnation Witchcraft; Curse from God or gods Ancestral spirits	Let live; Avoided to be seen by pregnant women	Overprotection rejection, sent grandparents	Informal Education	None

Source: Kisanji (1993) Special Education in Africa.

Training of Special Education Teachers

Concerns about the lack of programs for special education teachers have been raised by some educators. Possi (1986) noted that some teachers in integrated schools expressed the need for training. The teachers lamented that they lacked skills in handling students with disabilities in integrated classrooms. It is unfortunate there is only one special education teacher training program for primary school teachers in the country. Tabora College of Education offers specialized training for teachers of disabled children. The college, situated in Tabora town, opened in 1976, to offer courses for teachers of students with visual and hearing impairment. In 1983, a course for teachers of students with mental retardation was offered in the college for the first time. The course duration varies from 1- 1/2 years leading to certification in special education. The number of teachers trained in Tabora does not meet the needs of existing schools and institutions. Further, the college lacks trained tutors. To cite one example, in 1989 there was only one tutor in the whole college qualified to train teachers of children with mental retardation (Eklindh & Nchimbi, 1989). It is difficult to have a multiplier effect of fully qualified teachers from such an institution. Also, the University of Dar-es-Salaam offers an introductory course for special education for one term, with no major in any type of disabilities. Such limited programs cannot produce fully qualified teachers.

The Ministry of Education and Culture offers a few scholarships for training teachers in foreign countries, mostly in Europe, but these may not cater to the country's needs. In 1991-92 there were teachers trained in different fields as indicated in Table V.

Table 5

Number of Teachers Trained Abroad in 1990/91 Financial Year.

Number of teachers	Type of Course	Duration	Country	Certification
2	Hearing impairment	1 year	Britain	Degree
2	Hearing impairment	1 year	Britain	Diploma
1	Visual handicap	2 years	Britain	Diploma
1	Hearing impairment	1 year	Malawi	Certificate
4	Hearing impairment	3 months	Holland	Certificate
2	Visual impairment	6 weeks	Norway	Certificate
1	Mental Retardation	6 weeks	Norway	Certificate

Source: Ministry of Education and Culture ; 1990/91 Annual Report (1991)

Table 5 shows that there were more teachers of the hearing impaired trained abroad than those of the other types of disabilities. One wonders why there were no teachers sent for training in programs for students with behavioral disorders, gifted and talented, learning disabilities or even specialists in assessment. The aforementioned types of exceptionalities and services are not provided for in the country and should have been given priority in teacher training.

The 1990-91 annual report (Ministry of Education and Culture, 1991) also indicates that there were short courses carried out locally in Songea, Tanzania, in which 20 teachers for the hearing impaired and 10 for students with cerebral palsy and mental retardation received training. Again, there were more teachers who received training for teaching students with hearing impairment than for any other disabilities. There is need to provide more training for teachers of children with disabilities and exceptionalities.

Curriculum

The Institute of Curriculum Development, under the Ministry of Education and Culture, is in charge of preparing curricula for children with disabilities. The Institute has two curricula developers who are assisted by special education administrators and trained teachers in the preparation of special education curricula through writers' workshops and/or seminars. Such shortage of curricula developers calls for training of more specialized curricula developers to handle curricula for various exeptionalities. The basic approach used in curriculum development is modifying regular school curricula for exceptional children. For example, there are Braille transcribers who write Braille and talking books. Also total communication and sign language as well as lip reading are used in classroom interaction with the hearing impaired. The means of communication to be used in schools depend on the organizations sponsoring the schools.

One of the problems facing the education of the hearing impaired children in Tanzania is that the country does not have its own sign language, therefore students have to learn sign language from other countries which makes it difficult to communicate, considering the fact that the children have their own tribal languages in addition to the national language, Kiswahili. However, the government policy insists on total communication which is slowly taking place. As with children with mental retardation, plans are still on the way to refine the current curricula.

Special Equipment

Students with visual handicaps use equipment such as Perkins braillers, abacus, embossed diagrams, typewriters, radio tapes, and cassette recorders to facilitate their learning. Shortage of special equipment affects students' performance. Possi (1986) found an acute shortage of learning and teaching material in both integrated and special schools for children with visual impairment. There was a very poor book to pupil ratio of 1:6 which undoubtedly have affected the students' academic performance. There is need for students to have sufficient teaching and learning materials to facilitate their learning.

Vocational Skills

Various arts and crafts such as weaving, sewing, tailoring, carpentry, and basketry are taught to children with disabilities. These skills enable children to become future self-reliant citizens. However, at times it is not possible to teach these skills to students due to shortages of qualified manpower and equipment. Further, there is no career guidance and counseling for people with disabilities in Tanzania (Possi, 1992). Therefore, children's talents and interests are not discovered, hence not explored and nurtured.

Some Recommendations for Expanding and Improving Special Education Services In Tanzania

The paper has examined the existing special education services in Tanzania. Over the years there has been a great improvement in special education services. The improvement has been facilitated by social, political, and economic factors. This improvement, however, has not been without pitfalls. There is an imbalance in the provision of services. For example, there are more services for students of hearing impairment in terms of schools and teachers. More boys than girls receive special education services and that some types of disabilities such as behavioral disorders, low vision, and exceptionalities like the gifted and talented are not addressed. There are shortages of trained teachers, teaching and learning material, as well as problems pertaining to curricula. Further more, there are more special education services in rural than urban areas.

Consistent with the discussion of special services for primary schools in Tanzania, the following recommendations are made:

1. Enrolment of students in special education must be increased through implementation of national child count and early assessment programs for early registration. Formulation of a strong early childhood policy may allow better early childhood assessment and placement services. Further, there should be training for assessment personnel.
2. Efforts should be made to train more teachers, especially in areas and types of disabilities or exceptionalities that have not been addressed such as gifted and talented, behavioral disorders, low vision as well as language disorders.
3. Special education teaching methodology should be one of the components of teacher education.
4. More research should be carried out on the attitudes of parents toward education of children with disabilities, as well as folk beliefs regarding disabilities.
5. Access to special education services must be equally available across gender and type of disabilities.
6. Training for more curriculum developers is essential in order to have specialized personnel in different exceptionalities.
7. Programs that educate and counsel parents of and children with special needs should be developed and implemented.
8. Locally available material should be utilized in preparing some special equipment. For example, at present white canes for the mobility of students with visual impairment are imported from Sweden while there may be possibilities of manufacturing them locally.
9. Books with enlarged print and equipment for enlarging prints such as magnifiers should be available to students with low vision.
10. Classroom arrangement and lighting should take into consideration the problems of students with physical disabilities, sight problems such as low vision, astigmatism and myopia.

It is important to provide services for children with disabilities. Nyerere, the first president of Tanzania reiterated that the handicapped children

> ... are not less than human beings. They are not idiots nor vegetables. They are human beings .. ... It is our obligation to ensure that these children have the opportunity to enter regular schools and to make sure we help them in their problems (Daily News, 1974).

Implementation of the suggestions and recommendations would facilitate "Education for all' in Tanzania and help the nation realize its goals of Education for Self Reliance and equality among her citizens.

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International Journal of Special Education
1994, Vol. 9, No. 1

A COMPARISON OF REFORM IN SPECIAL EDUCATION IN ENGLAND AND IN KENTUCKY, USA

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Educational reform is a movement that has become important in many countries as increased technology and global interaction allow for comparisons of educational and economic attainment. Reform has taken several forms over the years. It may be a new classroom practice, such the use of manipulatives in teaching math skills. Fullan (1992) refers to this type of change as a level one change. Or it may be a broader stroke, a level two change, such as the movement to teach students with disabilities in regular schools and classrooms. This paper addresses level two change.

Educational reform or change is not an event, but rather a process. From the initiation or adoption of the change, to the beginning implementation and on to the real *change* or institutionalization of the particular practice, the process is complex. Often, it takes years to fully implement change. Many changes are introduced and may seem to be implemented. However, if only the surface structure changes and there is not a true commitment to the belief system of the change, nothing really happens. An example in some districts in the United States has been the move toward mainstreaming, or serving students with disabilities in regular schools and classrooms. Some teachers know students with special needs have a right to be in regular classrooms, but, if the teachers are not willing to accommodate or value those students and see them as able to learn, the inclusion will be superficial and the education of those students will not be an improvement over a segregated pull out program.

Recently, the British Government introduced substantial and radical reforms of the whole educational system (Education Reform Act, 1988). Similarly in Kentucky, reform legislation has focused on regular education (Kentucky Education Reform Act, 1988). In both systems, legislation has had implications for pupils with special educational needs. (Office of Special Education Programs, 1991).

This paper explores the issues surrounding the recent legislation in two education systems. These legislative acts have sought to improve schools and educational standards generally, and to meet the continuing need to adequately address the aspirations of parents and teachers of pupils with severe learning difficulties and disabilities. It is not possible in this paper to explore fully these implications. Certain of the reforms have been selected as offering interested bases for comparing and contrasting responses to legislation in Kentucky and England.

Background

Two pieces of legislation in the United States have led to major reforms that impact on children with special needs. The first legislative act, Public Law 94-142 was passed by the United States Congress in 1975, and provided mandates for securing the educational rights of children with special needs and their families throughout the country. This act extended to all children with disabilities the rights that had previously been enjoyed primarily by typical children (e.g. due process procedural safeguards, the basic right to a free and appropriate public education, parent involvement). In addition, it required planning and monitoring of education plans for each individual child whose disability met qualifications. This act has since been amended and renamed as Public Law 101-476, the Individuals with Disabilities Education Act (IDEA).

The second piece of legislation was passed by the Commonwealth of Kentucky in 1988. Although the provisions of this act apply only to that state, they reflect reform movements being considered or implemented in many states. One of the features of the Kentucky Education Reform Act (KERA) that is similar to reform discussions throughout the United States is that of defining curriculum in terms of learner outcomes for all children, with and without disabilities, and that apply to all school districts in the state. In fact, elected federal officials are in agreement that there should be national standards for students in regard to curriculum content (Jennings, 1992). While Public Law 94-142 and the subsequent amendments to that act pertain only to children with qualifying disabilities, the Kentucky Educational Reform Act (KERA) pertains to all children and youth, and does not have separate stipulations for children with disabilities. This philosophical shift indicates a greater realization of the need for inclusion of children with disabilities in programming for typical children. It should be noted, however, that the state must still assure that school districts are in compliance with provisions of federal legislation that refer only to children with disabilities.

In England, in the late 1960's and early 1970's, there was a growing concern about provision for pupils with significant learning difficulties. This concern reflected broad international influences, such as the civil rights movement in the USA, including the 1975 legislation, policies and practices in provision for children and adults with handicaps within the community in Scandanavian countries, and discussion at an international level of *integration* or *mainstreaming*. Reform was influenced also by more local and specific influences such as the growing number of children being placed in special schools, confusion and uncertainty regarding categories of handicap and identification, and uncertainty about the effectiveness of special school provision. Publications such as Segal's *No Child is Ineducable* (1967) fuelled the movement which led to the 1970 Education Act. This act brought children previously classified as ineducable and the responsibility of the Department of Health within the responsibility of the Department of Education. Further influences were an influential government Report (Warnock Report, 1978) and the 1981 Education Act. The social concern and changes in the legal framework led to moves to locate children, as far as possible, in ordinary schools, changes in the procedures for identification, changes in the terminology used to describe pupils, the increased involvement of parents, and a general increased willingness of teachers to change their attitudes and practices to working with pupils with special educational needs in the ordinary schools. Closer attention has been paid to preschool and post-16 (statutory school leaving age) provision. In addition to a consideration of those children who displayed enduring and challenging special educational needs, the Warnock Report pointed out that an estimated further 18% of the school population were likely to have temporary special educational needs at some time in their school lives and that they also deserved attention and appropriate support.

The Report and reforms were not all received positively and without criticisms. Concern about the absence of significantly increased funding, overly bureaucratic and lengthy procedures for determining the eligibility for special education support (statementing), resistance on the part of some teachers to receive pupils into their classes, anxieties on the part of special school teachers regarding school closures and changing of roles and responsibilities: all were symptoms of implicit tensions and problems neither resolved nor resolvable through legislation. Indeed, the Chairman of the committee herself, among others, wrote of some concerns soon after the legislation (Warnock, 1982). Overall, however, the legal reforms, changes in societal attitudes, changes in provision, procedures and practice, curriculum developments and the closer collaboration between teachers, parents and other professional groups may be said to have been broadly beneficial. More recent legislation (Education Act, 1988) has led to some concern regarding the momentum of the improvements made in the 1980's.

This paper focuses on comparing and contrasting three aspects of the reform movements in Kentucky, USA, and in England. Scotland, Wales and Northern Ireland reflect differences from the provisions in England and are not considered. The three components to be discussed include funding of education, provisions for curricula, and parental involvement.

Funding

Reform in Kentucky, USA, began in 1985 when a group of school districts brought a class action lawsuit against the Commonwealth of Kentucky (Kentucky Legislative Commission, 1991). The lawsuit charged that the level of funding for education varied so greatly from the poorest districts to the wealthiest districts that educational opportunity was not equitable throughout the state. The complaint also stated that funding was not adequate. In 1989 the Kentucky Supreme Court ruled that the public school system was unconstitutional. The ruling charged the legislature with implementing total reform of the educational system. This action was the basis for the sweeping changes brought about by KERA (Kentucky Legislative Commission, 1991).

Funding provisions are divided into state support and local support. The state funding has been titled *Support Education Excellence in Kentucky* (SEEK). The goal of SEEK is to guarantee an equitable and adequate amount of money per pupil with full implementation in 1994. SEEK provides that a guaranteed amount of money per pupil be provided throughout Kentucky. Funding is calculated on the previous year's average daily attendance. Adjustments to SEEK include the costs of educating at-risk (low family income) children, educating exceptional children, and transportation costs in the district.

The Exceptional Child Add-On funding is determined by calculating the number of children qualifying under the federal Individuals with Disabilities Act or a federal basic skills remediation program. Each child is then classified into one of three levels of support depending on the category and severity of the disability. In 1993-94, the district is provided an additional $5,687 for each of the most severely involved children, $2,831 for each child with less severe disabilities, and $581 for each child who requires only speech/language services. This state allocation includes the money generated at the Federal level and distributed to the states to pay for excess costs to educate children with disabilities. Additional funds are provided for preschool education, extended school year, technology, and professional development. SEEK has resulted in some of the wealthier districts getting less money than they had previously been allocated, and this has been contested. Unfortunately Kentucky is currently experiencing revenue shortfalls and the formulas for funding are being looked at very carefully. During the past year the late announcement regarding allocations, then changes in those allocations, caused a great deal of confusion.

A minimum level of local support is required. This funding is derived from a tax based on the assessed value of property and motor vehicles in the district, and taxes on utilities. Additional revenues may be provided by school board action based on a percent of the SEEK guaranteed level, or by vote of the people. The state will equalize the increase provided by school board action.

In the United Kingdom, a major innovation in funding has been the transfer of many aspects of school management, including budgetary control, from local authority control directly to the Headteacher (Principal) and Board of Governors. The package includes other measures such as formula funding, appointment and dismissal of staff, and staff appraisal. Local authorities are required to delegate at least 85% of their potential school budget to schools. This transfer has occurred within an overall reduction of funding available to individual schools. A further development has been the offer to schools of opting out of local authority control to *grant-maintained status*, involving direct control and improved funding by central government.

The procedure carries, in addition to certain operational advantages, considerable financial benefits. Many of the schools already opted out are former *grammar school*, or schools with a high local reputation for academic success which make them attractive to parents seeking this type of education for their children. One advantage to opted-out schools is a greater degree of control over selection of students. This control may limit opportunities offered to children with special educational needs.

As Wolfendale (1993) points out, there are weaknesses in the assumption by central government of control of education. At school level, rights may be preserved but changes in local education authority (LEA) influence, diminish or destroy certain forms of complaint and redress immediately and locally available to parents. The struggles by parents and professionals most concerned with special educational needs (SEN) to ensure adequate resourcing and children's rights do not seem to be reduced by these changes.

Comparison

In the area of funding, there are several similarities between the two countries. Both have local control of funding, and in both there are concerns about the adequacy of funding available with the economic problems in both countries. Because available funds may not be earmarked for services for students with special needs, there is concern that the money may be disbursed for other services. On the other hand, some have expressed concern that funding for special education may drain money available for typical children. Both countries are attempting to find the most efficient use of funds for effective services.

There are two major differences in funding between the countries. In the US, funds are allocated in a four tier system, from federal to state to local agency and then to individual schools, although there are proposals to allocate federal funds to local school districts to develop their own reform plans (Jennings, 1993). Funds also are still tied to number of children eligible for special education services. In England, after a long period of three levels of administration (national, local authority, school), a two tier system is emerging (national, school). The basis for additional support for special needs is a *Statement*. After a child has been statemented (a legal procedure), there is a legal obligation to provide for the additional assistance identified in the statement. During the last three years, with decreasing funding, the LEA has been responsible for ensuring proper provision for statemented children. Beginning April, 1994, greater control of budgets for special needs will pass to mainstream schools and also to special schools. A consequence may be a reluctance on the part of local authorities to statement children, thus avoiding additional costs. There is considerable uncertainty about the possible effects of these changes upon the range and quality of provision for those with special educational needs.

Curriculum Reform

In Kentucky, KERA established a *Council on School Performance Standards*. This Council was charged with determining what all students should know and be able to do, and how learning should be assessed. From statewide focus groups and telephone interviews came the six broad curricular goals that apply to all students, those who are typical as well as those with special needs. The Six Goals for Schools of the Commonwealth are (1) Use basic communication and mathematics skills; (2) Application of core concepts and principles in math, science, social studies, arts and humanities, practical living studies, and vocational studies to situations similar to what they will encounter in life; (3) Individual self sufficiency; (4) Productive team membership in family, work group or community; (5) Thinking and problem solving in a variety of situations; and (6) Connection and integration of knowledge. For the six goals, seventy-five learner outcomes have been developed. For example, for the goal of applying core concepts and principles, a learner outcome is *students demonstrate understanding of measurement concepts*. One of the learner outcomes related to the goal of individual self sufficiency is *students demonstrate the ability to be adaptable and flexible through appropriate tasks or projects* (Kentucky Department of Education, 1993).

Note that basic skills are not the entire focus of the curriculum. People across the state had emphasized the need for applications to real-world experiences, personal attributes, responsible membership in family, work and community groups, and problem solving. These goals then enlarged the scope of school curricula for all children, and in many respects came to more closely resemble a broader focus that has been characteristic of special education programming.

For youngsters who qualify for special education services, Federal legislation still applies. Part of the legislation mandates that an Individual Education Plan be developed for each child. For each child, an interdisciplinary team, which includes the parents and the child as appropriate, meets to determine the child's present levels of performance (strengths and weaknesses), the individual goals and objectives for the child, who is responsible for implementing the educational program, and when and how the progress will be evaluated. With the passage of KERA, this Individual Education Plan also now stipulates if the child's strengths and weaknesses will adversely affect accomplishment of a learner outcome.

The final draft of the curriculum framework was completed during 1993 (Kentucky Department of Education). This framework provides more information on the goals and learner outcomes, and offers suggestions for programs to achieve those goals and outcomes for all students.

Implementation of curricular reform necessitates changes in delivery of that curriculum. The primary programs are implementing this integrated curriculum for students from their fifth year of age until they are ready to begin fourth grade. Many attributes of this program are similar to current education practices in the United Kingdom. Some features include continuous progress; multiage, multi-ability grouping; developmentally appropriate curriculum; hands-on, activity centered curriculum and methods; reporting to parents without *grades*, but more descriptive of student skills attained. One problematic area is the place of Kindergarten in the Primary Program. Most Kindergarten programs are half-day experiences, and it has been difficult to maintain the continuity of a full day program with the inclusion of children who are present only one/half a day.

The Primary Program seems to be facilitating the philosophy in the United States of inclusion, that is serving youngsters with special needs in the regular classroom. Because the primary programs emphasize a hands-on, activity oriented approach with groups that are already multi-age and multi-ability, more children with disabilities may be successfully integrated at the primary level.

The Kentucky Instructional Results Information System (KIRIS) measures student progress toward Kentucky's learner outcomes. KIRIS assesses how well students apply classroom-learned knowledge and skills to solving real-life problems by measuring performance in three ways. First, all students in grades four, eight and twelve maintain a portfolio of their best work in mathematics and writing throughout the year. The quality of this work is reviewed by auditors from outside the district. A few portfolios from each district are sent to the state for reliability checks. The state also may visit a district and conduct random reliability checks.

Second, students apply knowledge and skills to solve real-life problems in performance-based events. This assessment covers traditional content areas as well as other domains defined in the learner outcomes, such as vocational studies, practical living, and arts and humanities. The assessment tasks were designed by various task forces throughout the state, and require students individually or in groups to address problems encountered in *real-life* situations. Students at the fourth, eighth and twelfth grades are given at least one such item, but the various items are assigned to different students so that all the items are covered. Every student, including those with disabilities, are given an item.

Third, each spring, students in grades four, eight and twelve are tested with an instrument patterned after the National Assessment of Educational Progress (NAEP); results can be compared to national student performance tasks. Kentucky is the first state in the nation to compare state results to NAEP data. Districts may choose to assess students in the other grades annually to monitor progress toward goals for education improvement.

KIRIS results are reported on four levels, distinguished, proficient, apprentice and novice. The distinguished level indicates that the student has deep understanding of the concept or process and can complete all important parts of the task. The student can communicate well, think concretely and abstractly, and analyze and interpret data. Proficient means that the student understands the major concepts, can do almost all of the task, and can communicate concepts clearly. At the apprentice level, the student has gained more understanding and can do some important parts of the task . The novice level indicates that the student is beginning to show an understanding of new information or skills.

Students do not receive numerical or percentile scores, but districts do receive state data for comparison with local school performance. The assessment measures both student progress and school success. Schools will be evaluated on the progress students make from one assessment period to another. Schools that do well will be rewarded; schools that do not will be helped in their efforts to improve. The state has developed an Accountability Index to calculate a threshold for each school (Kentucky Department of Education, 1992).

In England, the 1988 Act provided, for the first time in recent history a formal curriculum consisting of core subjects (English, Mathematics, and Science) and foundation subjects (History, Geography, Music, Physical Education, Technology, and from age 14, a Modern European Language). The curriculum is ordered within 4 key stages. These stages are defined by reference to the age of the majority of pupils in the class and teaching group, corresponding to chronological ages of 7, 11, 14 and 16. Within each subject there are attainment targets, currently ordered in 10 levels and detailed programmes of study. Significant features in this discussion are the notions of access and entitlement. *The*

Education Reform Act (1988) affirms that every pupil registered in maintained schools, including maintained special schools is entitled to a balanced and broadly based curriculum. These principles have not been disputed. Their implementation in practice has! Concern was expressed at the outset regarding many children who because of the severity of their difficulties were unlikely to move beyond level 1. The desirability of pupils with special educational needs learning a modern European language was questioned (though it is interesting to note just how successful some schools and enthusiastic teachers have been already in introducing this subject). Schools are allowed to withdraw statemented children from formal assessments in certain circumstances and to suspend pupils from schools for in some cases, disconcertingly long periods of time.

The Audit Commission report (1992), reviewing a decade of provision for special educational needs since the implementation of the 1981 Act, confirmed that the quality of some lessons had been affected by lack of space, general absence of assessment and associated teaching response to individuals and in some cases low expectations.

The level of learning experience for students with Special Educational Needs (SEN) was reported as virtually the same in both mainstream and special schools. In the absence of detectable differences in effectiveness, the priority is placement in the mainstream. Within mainstream support for individuals within ordinary classes is preferred to withdrawal groups. However, while this stance is preferred, additional adult support for individuals is seen as crucial if students are to maintain their position in mainstream classes. Effectiveness is dependent upon many factors such as the nature of the lesson (teacher talk, video, scientific demonstration, etc.). Nevertheless with careful targeting and planning, the support of additional adults could have a significant effect. The Report noted a concern that a greater proportion of older students are less likely to meet adequately the demands of mainstream classrooms, even with support. There has been a consistent movement toward the greater use of extra adult support in ordinary classrooms (consultants, special education teachers, auxiliary support, parents, volunteers, etc.).

The Report indicated however, the likelihood of increased need for special units attached to mainstream schools, similar to a pattern observed in Denmark. The wide range of individual special needs encountered across age, schools and subjects makes the development of coherent responses difficult.

In this climate of openness and scrutiny, formal tables of public examination results and truancy rates are currently being developed. Many parents and teachers of pupils with special needs are concerned that schools will be reluctant to admit too many students whose attainments in public examinations are likely to depress overall levels of attainment when success is likely to be viewed use predominantly academic criteria.

Overall, beyond the rhetoric of access and entitlement, the Education Reform Act paid little detailed attention to the education of students with special needs and the operation of the Education Act (1981). The extent of this concern, even discontent, is reflected in an article written by Warnock (1992) in which she argues that the system of special education needs assessment which her committee set in place in 1978 is now failing thousands of children.

Many individuals and small groups of British researchers suggest that provision for students with special educational needs may be adversely affected.

In general, there is no evidence of a reduction in local authority commitment to support services. The demands of schools for more individual support teachers to meet the requirements of more statemented children, changes in recruitment and management, locus of responsibility for support staff and other concerns related to the funding and its effect on provision directly and indirectly, are all indicators of fragmentation, short-termism and lack of coherent strategy.

Comparison

In the area of curriculum, similarities also appear. Great Britain has established a national curriculum for all children and Kentucky has established learner outcomes for all children. Discussions in the United States are indicating a move toward a national curriculum and national assessment. A second similarity is in the use of a whole language approach toward teaching literacy. A third similar curricular focus is in improvement of regular education so that fewer students need to receive special education services outside of the regular education setting.

There are some critical differences in curricular focus however. The National Curriculum in Great Britain is organized into core and foundation subject areas. There are some cross curricular dimensions, and ten levels of attainment for each of four key stages of development. The curriculum in Kentucky is based on learner outcomes that are more broad based than traditional subject areas with a focus toward integration across disciplines and an emphasis on authentic, real life learning activities.

There are some similarities in the area of service delivery. Both are moving toward more inclusion. The primary school concept with multiage, multiability groupings of young children is also being used in both places. Both see a need for additional preparation of teachers in order to appropriately meet the needs of students within the inclusive settings. The major difference in service delivery is that reform in Great Britain extends for children from age 6 to 18 years of age. In Kentucky, reforms in delivery of services are not yet mandated at the secondary level, although restructuring at the secondary level is being discussed .

In the area of assessment, concerns have been expressed in both countries about the inclusion of the special education population in school wide assessment, since these students scores may bring the school average attainment indicators down. In Kentucky, special education students must be included in the school wide assessment, while in Great Britain, there are provisions for exclusion of special needs students from the testing. The assessment focus is also different. In Kentucky, the learner outcomes have been integrated into event tasks, as well as portfolio and traditional questions. There is more qualitative evaluation of student achievement. In Great Britain, standard assessment tasks at the end of each key stage were prescribed in the 1988 education reform act.

Family Involvement

In Kentucky, Family Resource and Youth Service Centers are being developed in areas where at least 20% of the students qualify for free meals by virtue of low family income. The purpose of these centers is to serve the economically disadvantaged in the community, although all community members may utilize the services. Family resource centers are or will be in or near elementary schools; they identify and coordinate existing services such as preschool for two and three year olds, day care for after school and in the summer, a program for new and expectant parents called *Families in Training*, and other services families might need.

The Youth Service Centers are in or near schools serving students over 12 years of age. The services they may provide include referral to health and social service agencies, employment counseling, summer and part time job development, and drug and alcohol counseling. These centers are being phased in over the next four years, and about half of them are now opened. Since low income and minority families are overrepresented in the special ed population throughout the nation, this provision potentially could be very positive for them. Someone might need to know where there are openings for day care for their child, for example, so the role of these centers is primarily one of coordination of social services rather than actually providing those services.

In the United Kingdom, there has long been a recognition and practice in schools of the value of parental involvement. For example, the Plowden Report (1967), now the subject of criticism in some circles, recognized the value of partnership with parents - children's first educators. In the last decade, a series of Acts (1970, 1980, 1981, 1986, 1988, 1992, with further legislation imminent, 1993/4), parental rights have been extended considerably in relating to, for example, participation in school government, knowledge of children's progress and influence on decision-making and school choice. These changes are articulated not only in the Acts but in a number of Citizen's Charters, including a *Parents' Charter* relating to education.

Such an increase in rights, empowerment and involvement is welcomed, particularly by parents of children with SEN. As Wolfendale (1993) points out, there are a number of uncertainties and paradoxes, requiring caution in analysis of the governments proposals.

Comparison

In both reform movements, a major focus has been more involvement of families. In Great Britain this has been multifaceted ranging from informal initiatives by individual teachers and schools to local authority or government sponsored programmes, whereas there are specific structures established in Kentucky both through federal legislation and state reform, specifically in regard to the Family and Youth Service Centers. There is a longer tradition of direct parental involvement in school in the USA than in the UK. It would be interesting to compare further possible different perceptions and expectations of parents regarding the integration of children with special needs, including the beliefs about power and control over decision making.

In both communities the incidence of learning difficulties is linked to broader social and environmental factors similar to those *deprivations* addressed at earlier times, e.g. Headstart in the USA and Social Priority Areas in Great Britain. Such projects are still being initiated at the government level in both communities and directed at similar social concerns. There remains a continuing doubt about the availability and quality of evidence which address directly the results of such initiatives and the part which it might play in improving parent-school partnerships. At this time of major radical reform in both communities, perhaps this area of lively activity might be more systematically researched and evaluated.

Conclusions

In both the Kentucky and England, features of radical educational reform, within a declining budgetary provision impact upon special needs in ways which make parent, professional groups and students concerned that advances made in the 1980's may not be sustained or developed. Despite constant rhetoric, the full benefits of integration or mainstreaming may be rendered more difficult to achieve and provision for individuals more difficult to realize for several reasons. For example, special education is built on laws, regulations and rights. There are many aspects of serving children with disabilities that may be counter to reform e.g. forms that are required by state regulations to comply with federal laws and regulations may be even more cumbersome where paired with new state reforms. New efficient methods need to be developed. For example, now in Kentucky, when strengths and weaknesses of individual children with special needs are listed in the annual plan or IEP, it is also necessary to indicate how the students present level of performance may affect achievement of one of the outcomes mandated for all children. Complex laws and regulations may be necessary, but they also may interfere with the implementation of innovations. Also, special education has an individual rather than group focus. Special educators plan for and assess the progress an individual is making . In order to determine if a reform is successful in helping students accomplish the desired outcomes, the progress whole groups of youngsters needing special education services must be documented. With the individual focus in special education though, a particular program may not be ideal for a given individual

There is a certain resistance of special education to reform. Many of the learning difficulties remain intractable unless addressed through persistent and intense human, material and ultimately financial investment. Within radical and comprehensive reforms, outlined briefly here, special education may remain marginalized. As model from the market place are applied to schools, commitment to special education may be seen as a window into of organizational response (at whatever level) to essentially individual personal needs. Those individual needs must be kept in mind, while accepting and implementing innovations that provide maximum benefits. Consideration must be given to how the individual and group success rates are balanced. In addition, the cost must be balanced against the effectiveness of the innovation.

While the entitlements written into the recent legislation seem to offer a positive framework within which to improve provision for special education, there are indications that any improvements will not occur spontaneously. The optimism and commitment of those directly concerned with special education will be in demand as the full implications of the reform in Kentucky and England unfold.

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International Journal of Special Education
1994, Vol. 9, No. 1

MENTALLY RETARDED CHILD IN INTEGRATED KINDERGARTEN AND SCHOOL IN POLAND

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Before 1989, there was a separate system of education at preschool and primary school level for nonhandicapped and handicapped children. This system was inflexible and inefficient. It has contributed to a sharp segregation between handicapped and nonhandicapped children.
The introduction of new educational forms became possible because of the political changes in Poland (the transformation process from totalitarian system to a democratic one). Over the past few years, all kinds of social, private, and religious schools as well as other forms of alternative education, including integrated groups on preschool and primary school level, have originated.

The integration of handicapped children into the mainstream pre-school and school system of education started four years ago when the first integrated kindergarten was created in Warsaw by the St. Joseph Parish Church in Deotymy Street (the costs of this project were covered by the State).

Currently there is no system of integrated education in Poland so far. In the present situation, the legislative regulations are inadequate, because they apply to a separate system of normal and special education. Nevertheless, the idea of integration has been received very positively and have met with great interest by local communities. The initiative, enthusiasm and determination of individual teachers, psychologists and, of course, the parents of handicapped children account for creating integrative education groups.

In Poland over the last four years, nine integrated kindergartens and eight primary schools with integrated classes have been established in Warsaw alone. There are more integrated institutions of this kind across my country, mostly in other big towns, some of them based on the model we are developing in Warsaw.

There are other experiments in integrated education in Poland, such as: special classes for handicapped children within a normal primary school, or the integration of children with various handicaps, into the regular class except for the mentally retarded.

Integrated Project

The integrated project was launched four years ago and has the approval of the Polish Educational Authorities. Our integrated groups were the first of this kind to be funded in Poland. They are based on the organization and structure of similar groups developed in Hamburg, Germany.

The general principles of the integrated groups are the following:

-handicapped and nonhandicapped children of integrated groups come from the local community;

-reduction of the number of pupils to 15-18

-ratio of handicapped to nonhandicapped children: 1:4. Various kinds and degrees of handicaps are included (physical, mentally retarded, learning, emotional disorders, autism and deafness);

-a team of two teachers work simultaneously with the group (general education teacher and special pedagogue);

-the use of individualized and creative approach to meet the needs of each child;

-innovative didactic forms;

-complex therapy (physical, psychological and medical);

-cooperation with parents and local environment;

-continuation of care and learning process and stability of integrated groups (some handicapped children who started in the integrated kindergarten in 1989 have reached the 3rd form of the integrated primary school under the guidance of the same special pedagogue).

In Warsaw 104 children are involved in our integrated education project, of these, 27 are handicapped children, 16 of whom are also mentally retarded..

Social and Emotional Aspects

Within a separate system of education for handicapped and nonhandicapped, the mentally retarded children mentioned above would probably have been offered an individual course of education, which means they would have been excluded and isolated from the other children. Moreover, some of them would probably have been placed in institutions of special education, whereas in the integrated groups and classes they have a perfect chance of being, learning and playing together with normal mainstreamed children of approximately the same age (usually handicapped children are 1-2 years older than nonhandicapped children).

Our experiences show that integrated classes are a source of natural interactions between nonhandicapped and handicapped children. Nonhandicapped children provide proper motor, behavioural and speech patterns for handicapped ones. Under such circumstances - during lessons, games and common meals -handicapped children learn to know and use their potential abilities as well as to accept their limitations.

Such children are usually overprotected by their families, isolated, and they often function below their potential abilities because of a minimalization of the demands. According to our experiences, they were often unable to eat, dress, wash, etc., independently when they were admitted to the integrated kindergarten or school. Everyday contact with normal mainstreamed children stimulates the activity and motivation of the handicapped ones. Two examples: Michael, a nonhandicapped boy, likes Ella, a girl with Down syndrome, very much; and Irek, an outstandingly talented, hyperactive boy likes to play with Damian, a tetraplegic, practically speechless child and sometimes invites him to his house. The teachers and special pedagogues also contribute to creating the atmosphere of mutual acceptance in the classrooms that ensures a feeling of safety of every child.

Organization of the Didactic Process

Activities in the integrated groups and classes require a differentiation of methods, aids and program content in order to meet the individual needs and abilities of the pupils. This is made possible by a reduced number of pupils in the classroom and the simultaneous work of two people with the group: a general education teacher and a special pedagogue.

Integrated classes work on the basis of an obligatory school program, which, itself, is based on obligatory manuals. The special pedagogue has to adapt the program contents to meet the individual needs of a handicapped child. For example, a program designed for a mentally retarded child may include some elements of the programs for regular class, special schools and so-called life schools, all at the same time. The pedagogue tries to encourage handicapped children to join the didactic activities of the whole class to the greatest extent possible. However, as our experience shows, it is rarely accomplished. In some cases, it is neither good nor reasonable because it would not serve the development of a handicapped child.

Even when handicapped children do other things during group activities in an integrated kindergarten group or an integrated class, a whole spectrum of natural interactions occurs among children. Moreover, our observations certify that this is very beneficial for nonhandicapped, but especially for handicapped children.

We introduced a new didactic form of so-called *open hours* (2-3 hours weekly) based on weekly plans, which enables us to individualize our pedagogic work. The weekly plans contain a proposed set of tasks to be accomplished within the week. They are designed on the basis of a cooperation between the general education teacher and the special pedagogue. They are adapted to the individual needs and abilities of a child with regard to its personal interests. Tasks for handicapped children are to stimulate their motivation and interest. They are very often of re-educational character aimed at training the insufficiently developed functions of a child through multiple repetition. Properly selected tasks encourage handicapped children to do independent work and allow them to experience a positive feeling of success and accomplishment.

Therefore, for example, it is important that these tasks must not exceed the intellectual capabilities of a handicapped child. At the end of the week, *open hours* tasks are verified by the teacher and discussed with the pupil, while parents get written information about the child's current achievements, including instructions for working with the child. It is a form of partial, descriptive evaluation, which gives reliable information about the child's progress. In our project we apply the evaluation system of verbal and descriptive character to all nonhandicapped and handicapped children from the integrated groups on preschool and primary school levels.

In addition to program activities, special pedagogues use a number of techniques to aid the development of handicapped children within group activities. These are the following:

-regular training in self-service;
-Scherborne method exercises (cooperation of handicapped and nonhandicapped children);
-Bon de Part method;
-psycho-motor therapy;
-music therapy;
-large forms technique during artistic activities.

Besides group activities, regular individual exercises with a physiotherapist, speech therapist and psychologist are organized for handicapped children.

Cooperation with Parents

An indispensable condition for a the successful functioning of the integrated system is close cooperation with the parents. The school is open for parents and they are encouraged to take part in the lessons. When accepted by the teachers, they help with lessons with a given child who has some difficulty.

During the *work techniques* and craft lessons, parents can carry on several fields of interest according to their own capabilities and after a detailed discussion with the teachers. For example, one mother in one place of the classroom is sewing aprons with children interested in this work, while another one is making pots of clay, and the third mother is showing the children how to cook. Each child can decide and choose the group it wants to work with. We make use of the parents' jobs, their fields of interest and their experience.

In the case of parents of handicapped children, such cooperation has a very positive and therapeutic effect. It enables them to recognize better the capabilities and limitations of their children and also to learn how to overcome their difficulties. It promotes developing attitudes of acceptance towards handicapped children.

What Does Integrated Education Give to Mentally Retarded Children?

Special pedagogues and parents of mentally retarded children agree that these children have made a considerable progress in the social, emotional and motor spheres, especially in comparison with similar children from special education institutions. However, their progress in the cognitive sphere, evaluated by using intelligence tests, such as Terman-Merril and Columbia, is less significant with the exception of three children whose IQ clearly increased by 10 to 15 points in the Terman-Merril scale.

Finally, allow me to share with you a short analysis of the progress of mentally retarded children with integrated groups and classes. I have divided the children into three groups according to disorders coexisting with mental retardation:

Group 1: mentally retarded with cerebral palsy -10 cases;
Group 2: mentally retarded with Down Syndrome - 4 cases;
Group 3: mentally retarded with autism - 2 cases.

In Group 1: Slow but constant progress in the motor sphere, including manual skills: for example, a child using 2 crutches starts walking with the support of one hand of an assisting person; improvement in living skills; more efficient use of a pencil, considerable progress in the social and emotional spheres: increased motivation and wish to cooperate; expression of numerous positive emotions. Substantial progress in the cognitive sphere concerning speech, logical thinking and perceptive functions.

In Group 2: Considerable progress in the motor sphere: movements become smoother, great motor expression without anxiety, improvement in manual skills and self-service, substantial progress in the social and emotional spheres, little progress in the cognitive sphere: distinct improvement in verbal expression, communication and perceptive functions, e.g. recognizing letters and numbers.

In Group 3: The greatest progress in the social and emotional spheres: more and more they establish adequate contact with their peers; in the integrated class their unique gifts have been revealed: examples: Kinga, a 10-year-old girl, has a very good ear for music and sings beautifully, whereas Lukas, a 9-year-old boy, is artistically talented. Progress in the cognitive sphere is difficult to evaluate because of disturbed contact with these children, although we observe considerable progress in visual-motor coordination and improvement in concentration skills.

Our experience shows that autistic children benefit a lot from being in an integrated education class, which turns out to be an advantageous and therapeutically positive environment for them. Our experiences certify the benefit of integrated education for all the children taking part in it - both handicapped and nonhandicapped.

International Journal of Special Education
1994, Vol. 9, No. 1

WHAT IS EMPATHY?
THE ROLE OF EMPATHY IN TRAINING OF SPECIAL EDUCATORS

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There seems to be an agreement among psychologists that empathy is a complex phenomenon. In the theoretical model of Kalliopuska empathy means a holistic process in an organism, in which physiological, kinaesthetic, affective (emotions, sensitivity, momentary identification, as well as motivation), and cognitive (perspective taking, knowledge and experiences) components have been distinguished (Kalliopuska, 1983). Empathy is not only sharing various emotions with another person. It is important to find the resonance on the same wave length and keep it. Empathy includes also several cognitive components. Taking another person's role and finding his point of view are essential factors. The empathetic process is evidently indicated by a neural activation of the limbic system which reflects the stimulus to other areas of the brain and simultaneously both hemispheres act in empathetic process (Kalliopuska 1992).

Empathy is linked to helping behaviour and to more effective professional functioning and it is, therefore, nearly universally valued in helping professions (Williams, 1989). Empathy is very important for a positive development of people's interactions in many teacher - pupil situations.

As a results of the our study, prosocial attitudes of the students were correlated with the level of empathy and it's factors. There were correlations between individual differences in intelligence and neuroticism and empathy and attitudes towards disabled people.

The issue of teacher health and well-being is increasingly coming to the attention of everyone involved in the field of education, because healthy, happy and self-realizating person is the best model for his or her pupils. Studies into teachers' health have traditionally focused primarily on issues of teachers stress and burnout. Staying in longitudinal high level of occupational stress leads to long term disability (Jevre, Zingle, 1992). Studies suggest that personality rather than biographical variables is the more important determinant of individual differences in teachers' stress (Kyriacou, Sutcliffe, 1978). Extraversion, neuroticism, locus of control and hardiness are the most important dimensions of personality associated with teachers stress. Teachers who report greater stress are more introvertive, neurotic, and have external locus of control but hardy teachers experience lower levels of burnout.

One of the dimensions of personality, connected with psychical health, well-being and life satisfaction, is empathy (Kalliopuska, 1992).

What is Empathy?

There seems to be an agreement among psychologists that empathy is the complex phenomenon. In the theoretical model of Kalliopuska empathy means a holistic process in an organism, in which physiological, kinaesthetic, affective (emotions, sensitivity, momentary identification, as well as motivation), and cognitive (perspective taking, knowledge and experiences) components have been distinguished (Kalliopuska, 1983). Empathy is not only sharing various emotions with another person. It is important to find the resonance on the same wave length and keep it. Empathy includes also several cognitive components. Taking another person's role and finding his point of view are essential factors. The empathetic process is evidently indicated by a neural activation of the limbic system which reflects the stimulus to other areas of the brain and simultaneously both hemispheres act in empathetic process (Kalliopuska 1992).

Empathy and Behaviour

Various authors point out that empathy is important in many different situations. Empathy seems to have a significant role in the educational process, therapy, nursing, and other fields. Empathy is an feature of personality involving the capacity to respond emotionally and cognitively to other persons without loss of objectivity (Berger, 1987, in Williams, 1989). Empathy is linked to helping behaviour and to more effective professional functioning and it is, therefore, nearly universally valued in helping professions (Williams, 1989). Empathy is very important for a positive development of people's interactions in many teacher - pupil situations (Grzywak- Kaczynska, 1971), especially when the pupil is exceptional in some way (below or above the intellectual, social or emotional norms) and requires special treatment from teachers, in these cases empathy helps teachers to act in such way which minimizes social conflicts and disruption (Morgan 1983, 1984, Rembowski 1989).

Empathy has numerous connections with other elements of personality. According to several studies (see Kalliopuska, 1992) empathy is a characteristic of healthy personality and is negatively correlated to anxiety. An empathetic person has been noticed to be tolerant, human, psychically balanced and to have control over his impulses. He has a healthy self - image and can analyze accurately his own emotions and the emotions he has observed in others, and he makes sensitive evaluations of affects.

Empathy seems to have different roles (in therapy, communication, education, and social life) and its regulative role is influenced by its complex character. Numerous investigations show that empathy is a motivational factor in prosocial behaviours (Mehrabian & Epstein, 1972; Hoffman, 1975). Empathy is a necessary prerequisite for altruistic behaviour and is positively related to cooperation (Aronfreed, 1968). If an empathetic relation depends on affects, our behaviour is more unequivocal and predictable. An affective response is viewed as the primary mediator of prosocial intervention (Hoffman, 1975; Reykowski, 1979). Different kinds of reactions are typically exerted by the cognitive and affective facets of empathy. The influences of individual differences within emotional empathy on behaviour are typically immediate, direct, and involuntary, largely unaffected by deliberate, conscious processes. In contrast, the most cognitive variety of empathy typically affects behaviour through a more conscious and deliberate effort (Davis 1983, Szmukier, 1989).

Empathy in Education

The renewed emphasis on the psychosocial development of children has led to a greater interest in personality, attitudes, and affective qualities of teachers. Teachers create a climate of warmth, trust, and understanding by keeping open the channels of communication between children and themselves. The effective teacher must be able to perceive needs of children and predict their reactions in a variety of situations. Teachers in general, and especially when working with exceptional children, should be therapists rather than educators. For emotionally disturbed children affective skills of the teachers and their ability to give the feeling of internal comfort are more important than occupational competences (Morman, 1979). Empathy is no less important for teachers than for therapists (Grzywak-Kaczynska, 1971, Rogers 1980). In our previous study (Klis, Kossewska, in press) it was found that students of special education showed a significantly higher level of emotional empathy than students of other department, teachers of disabled children, and primary school teachers. But emotional empathy decreased with the age of teachers. It could be explained as being caused by the burnout syndrome. It means that profilactic treatment should be carried out in order for teachers to prevent the negative influence of this syndrome and for students of special education.

Aims of the Study

According to the idea of the holistic empathy we put the question whether the components of empathy are completely specific for this phenomenon or common with other psychological phenomena as prosocial attitudes, neuroticism and intelligence.

Prosocial attitude is a disposition which embraces cognitive, emotional and behavioural components. The question arises whether these components of prosocial attitudes have some common mechanisms with the empathy process or whether they are phenomena completely different and independent from one another. The same question could be asked about the neuroticism level (with its anxiety component) and its relation to the empathy process; whether empathy and neuroticism have some common mechanism or not. As cognitive components of empathy are emphasized we can put also a question about common elements of the mechanism of intellectual abilities and of the process of empathy. In the answer to our questions put above we have studied the empathy among students of the Special Education alongside the relations between empathy, prosocial attitudes and individual differences in intelligence and neuroticism.

METHOD

Subjects

The group of 121 students of the Special Education aged 18 to 20 were tested.

Questionnaires

The level of empathy was measured with *The Questionnaire Measure of Emotional Empathy* constructed by Mehrabian and Epstein (1972). The Mehrabian and Epstein inventory of 33 items measures aspects of emotional empathy. The scale for answering is very wide (-4 = completely disagree to +4 = completely agree). The split-half reliability of the empathy scale was .84 for N= 202 adults.

Prosocial attitudes were measured with Attitudes Questionnaire by Klis, Kossewska (1992). The Questionnaire was composed of 30 items divided into three main parts: a) general attitudes of subjects towards disabled people, b) attitudes of an ideal teacher towards disabled children, and c) attitudes of subjects towards mainstreaming in education and social life. The scale for answering was very wide 0 = completely disagree to 7 = completely agree)

Individual differences in non-verbal intelligence were tested by Raven Advanced Progressive Matrices.

Individual differences in neuroticism were measured with Inventory of Neurotic Symptoms constructed by Bizon (Wisniewski, 1969).

Results

The Factor analysis was applied to the results of the Mehrabian and Epstein Empathy Questionnaire because original subscales cannot be obtained by statistical criteria. The scree test was used to find general factors. The method is based on a graphic presentation: latent roots are plotted against the factor number in the order of extraction. The point at which the curve straightens out is used as the maximum number to be extracted. We were able to differentiate four main factors, based on the ortogonal solution by Principal axis factoring and Varimax rotation, resulting in items of .30 or higher on at least one factor. We obtained four main factors which explain 27.2% of the variance of the 33 variables and are a little bite different from Kalliopuska (1983), who distinguished five main factors of Mehrabian and Epstein Questionnaire in her study.

Table 1 is a presentation of the four factors we have differentiated, and their interpretation.

Factor I explains 10.5% of the variance and 38.6 % of the common impact of the four factors. This factor could be named *rejection of feelings and hardnend feelings*. This factor contains a cynical attitude to other people. It also embraces the capacity to reject another person's feelings and self control. Matters concerning people evoke an attitude of rejection and self-control which makes someone cold and rational. This factor include items from Kalliopuska's (1983) factor 2, 3 and 4.

Factor 2 explains 7.6 % of the variance and 27.9 % of the common impact of the four factors. This factor could be called *emotional receptiveness*. It is almost the same as factor I in the analysis made by Kalliopuska. This factor shows some similarity to the sympathetic tendency and the tendency to be moved by others' positive and negative emotional experiences, which were mentioned by Mehrabian and Epstein (1972). It also includes sensitivity to another person's feelings which is strengthened by previous theoretical views (Rogers, 1980).

Table 1

Varimax Rotation, Analysis - Kaiser Normalization. Rotated Factor Matrix:

Questions in Mehrabian & Epstein Questionnaire	FACTOR1	FACTOR2	FACTOR3	FACTOR4
6 I find it silly for people to cry out of happiness.	.65642			
21 When a friend starts to talk about his problem, I try to steer the conversation to something else.	.65252			
28 It is ridiculous to be moved by contents of a novel or films.	.57199			
30 I become more irritated than sympathetic when I see someone's tears.	.51586			
22 I don't share other persons' laugh.	.50851			
2 People exaggerate when talking about animals' sensibility and feeling	.45887			
23 It is the cry and sob of spectators that make me laugh in the cinema.	.42259			
11 Most foreigners I have met seem cool and unemotional.	.37926			
27 I am very upset when I see an animal in pain.	.37284			
1 It is the sight of a lonely person that makes me sad.		.84287		
29 It upsets me to see helpless old people.		.67758		
16 Seeing people cry upsets me.		.54627		
12 I would rather work in the social service than in a factory.		.50427		
9 I tend to lose control when I am bringing bad news to people.		.45810		
17 Some songs make me happy.		.30993		
31 I become very involved when I watch a movie.			.61079	
8 Sometimes the words of a love song can move me deeply.			.58989	
18 I really get involved with the feelings of the characters in a novel.			.53618	
14 I like to watch people open presents.			.36390	
7 I am inclined to be effectively engaged in my relatives' problems			.31819	
20 I am able to remain calm even though those around me worry.				.66462
10 Environment has a deep influence on my mood.				.46204
24 I am able to make decisions without being influenced by people feelings.				-.41343
32 I often find that I can remain cool in spite of the excitement around me.				.38004
5 I become nervous if others around me seem to be nervous.				-.37747

Factor III explains 5.0 % of the variables' variance and 18.4 % of the explanatory impact of the four factors. This factor is similar to factor V in the Kalliopuska's analysis, and it could be called *readiness to identify oneself with others*. In this factor positive loading is obtained for the temporary identification with the role of another person, i.e. good understanding of other people's thoughts, feelings, and needs (Kalliopuska, 1983).

Factor IV explains 4.1 % of the variance and 15.1 % of the common impact of the four factors. It could be called *emotional control* and contains capacity for self control. Matters concerning people evoke an attitude of self-control which makes someone cold and rational.

The results of the Attitudes Questionnaire show there are three areas of prosocial attitudes: a) attitudes our subjects towards disabled children, b) attitudes of an ideal teacher towards disabled children, c) attitudes of our subjects towards mainstreaming in education and social life.

a) Our subjects declared the following feelings (Table 2) in contact with a disabled person:

Table 2

Attitudes of Students Towards Disabled People.

Feeling	Percent of the highest scores	Median
p14 - willingness to help	87	7
p20 - willingness to understand others' situation	73	6
p21 - need of contact with disable people	71	6
p13 - sympathy	43	5
p16 - mercy	8	1
p15 - anxiety	4	1
p19 - curiosity	6	1
p17 - aversion	0	0
p18 - disgust	0	0

In general, our group of students presented positive prosocial attitudes towards disabled people. They agreed they need the contact with disabled person and they feel sympathy, they are willing to help and to understand his or her situation.

b) Testing attitudes of an ideal teacher towards disabled children we obtained our students' ideas of teachers' characteristics (Table 3). Imagination of the ideal teachers of disabled children is projection of students' feelings and attitudes towards them. Students of the Special Education believed that the teacher of disabled children should be:

Table 3
Attitudes of Ideal Teacher Towards Disabled Children.

Feature	Percent of the highest scores	Median
p2 - patient	98	7
p9 - willing to help	90	7
p12- able to control himself	90	7
p3 - cordial	88	7
p4 - understanding of others' needs	88	7
p1 - lenient	82	7
p11- immune against stress	79	7
p5 - optimistic	76	6
p7 - tolerant	76	7
p6 - able to identify with others' feelings	74	6
p8 - professional in his work	66	6
p10- keeping emotional distance to others	35	5

In opinion of our subjects the main features of the ideal teacher of disabled children were: patience, willingness to help and an ability to control himself and other personality features, especially affective and prosocial skills. In their opinion good professional competences were not so important in working with disabled children as other features of personality especially prosocial and emotional skills. This conclusion is conformable to the results of Morgan (1979).

There was no agreement among subjects whether keeping emotional distance to disabled children was important for an ideal teacher or not. This result will be explained with Anova analysis.

c) Students' general attitudes towards mainstreaming in education and social life were also positive but not so emphatic as attitudes towards disabled children (Table 4). Most of the students agreed that disabled children should learn with healthy children, and that disabled people should work with healthy people and function actively within society.

Table 4
Attitudes of Students Towards Mainstreaming.

Integration	Percent of the highest scores	Median
learn with healthy children	73	7
work with healthy people	62	6
actively participate in society	48	5
have special privileges	39	4

Generally, our subjects declared positive attitudes towards mainstreaming. They agreed that integration in education and social life was a very good experience for disabled people which helps them to function properly in society. However, our students were aware that mainstreaming might cause some difficulties and problems not only for disabled and healthy children but also for their teachers and parents.

Our students thought that disabled people should not have special privileges. Such an attitude could result from thinking about disabled people as similar to others but, on the other hand, our students might be unaware of the needs of disabled people and their difficult situation in our country.

Having applied the Pearson correlation (see Table 5) between the students' attitudes towards disabled people and attitudes of the ideal teacher, we obtained some interesting results, presented below.

Table 5

Pearson Correlation Between Students' Attitudes Towards Disabled People and Attitudes of Ideal Teacher.

Cor:	P13	P14	P15	P17	P18	P20	P21
P1	.3877**	.2626*	-.0050	-.1933	-.2728*	.1235	.1961
P2	.1078	.2142*	.0254	-.1672	-.0737	.0631	.0335
P3	.1837	.2999**	-.1744	-.2518*	-.2462*	.1773	.2432*
P4	.1751	.3093**	-.0811	-.1592	-.0799	.2945**	.1448
P5	.0872	.1884	-.2389*	-.1540	-.1684	.1803	.1654
P7	.1477	.0350	-.0987	-.2182*	-.2155*	.0220	.1595
P9	.3504**	.4298**	.1062	.0074	-.0113	.2999**	.0380
P12	.0832	.4168**	-.1741	-.1449	-.1180	.3617**	.2967**

p1 - lenient
p2 - patient
p3 - cordial
p4 - understanding of others' needs
p5 - optimistic
p7 - tolerant
p9 - willing to help
p12- able to control himself
signif: *-.01 **-.001

p13 - sympathy
p14 - willingness to help
p15 - anxiety
p17 - aversion
p18 - disgust
p20 - willingness to understand others' situation
p21 - need of contact with disable people

Table 6
Correlations Between Procosial Attitudes, Empathy, Intelligence and Neuroticism

Cor:	INT	NEU	P1	P2	P4	P6	P13	P14	P17	P18
INT	1.0000	.1105	-.2259*	-.0291	.0401	-.0048	-.1529	-.1827	.1729	.0069
NEU	.1105	1.0000	.1582	-.0420	.0174	.2470*	-.0186	.0424	-.0218	-.0771
EMP	.0302	.0783	.2099	.0784	.2858**	.1227	.2800**	.1633	-.1526	-.1318
FAC1	.2590*	.1700	.0041	.0085	.1505	.1449	.0169	-.0355	-.0449	-.0055
FAC2	-.0200	-.0060	.3410**	.0840	.2391*	.0066	.3278**	.2129*	-.2462*	-.3557**
FAC3	-.3045**	-.0361	.3411**	.2521*	.3710**	.2351*	.1896	.3401*	-.0242	.0482
FAC4	-.0768	-.2657*	.0012	.0329	-.0359	-.0687	.0199	.0833	-.0843	-.0906

INT - intelligence
NEU - neuroticism
p1 - lenient
p2 - patient
p4 - understanding of others' needs
p6 - able to identify with others' feelings
EMP - empathy
FAC1 -FAC4 - factors of empathy
signif.: * - .01 ** - .001
p13 - sympathy
p14 - willingness to help
p17 - aversion
p18 - disgust

There were numerous correlations between the students' attitudes towards disabled children and those of an ideal teacher. It proved that students identify with imaginary teacher and project their own attitudes to him. Students with a high level of sympathy towards disabled people, willingness to help, and understanding of other people thought that ideal teachers of disabled children were more lenient, patient, cordial, showed understanding of other people's needs, were willing to help and capable of self control. Negative attitudes towards disabled people (anxiety, aversion, disgust) were related to thinking of teachers as strict, unemotional, pessimistic and intolerant people.

Having applied the Pearson correlation (see Table 6) we obtained some interesting results, presented below.

Prosocial attitudes of the students were correlated with the level of empathy and it's factors. More empathetic students felt more sympathy for disabled people than the students with low level of empathy and they thought that ideal teacher of these children should be more able to identify with other people's feelings. Emotional receptiveness (factor 2) was positively correlated with sympathy for disabled children and willingness to help them but negatively with aversion and disgust. Readiness to identify with others (factor 3) was also positively correlated with willingness to help. Both factors: emotional receptiveness (factor 2) and readiness to identify with others (factor 3) were connected with the opinion that the ideal teacher should show understanding of other person's needs.

As it could be seen in Table 6, there were some correlations between individual differences in intelligence and neuroticism and our variables of empathy and attitudes towards disabled people.

1) Non-verbal intelligence measured with Raven Advanced Progressive Matrices was positively related to factor I of empathy - rejection of feelings and hardened feelings and thinking that the ideal teacher of disabled children should not be lenient, but negatively to factor 3 - readiness to identify with others. More intelligent students rejected feelings of other people but simultaneously, were not ready to identify with others.

2) Level of neuroticism measured with the Inventory of Neurotic Symptoms constructed by Bizon was negatively connected with factor 4 of empathy, e.g. emotional control and positively with a belief that the ideal teacher of disabled children should be able to identify with others' feelings.

An interesting question for us was how the period of contact with disabled children differentiated attitudes of the students. One-Way analysis of variance and tests for homogeneity of variances were conducted. We have found pairs of groups significantly different at the .05 level in students' attitudes towards integration of disabled people with healthy people at work (F=6.58, prob=.002, Cochrans C=.488, P=.23). Students with a long or medium period of contact with disabled children (taking care on them during holidays, practising at kindergarten, having disabled child in the family), had significantly more positive attitudes towards integration of disabled people with healthy people at work, than students with no contacts with disabled children.

The ANOVA analysis of variance was used to find interactions between independent variables in their influence on prosocial attitudes. Two statistical interactions were found between the length of the period of contact and the level of emotional empathy which influenced the students' attitudes. Students' opinion that the ideal teacher of disabled children should have high emotional distance (F=3.192, p=0.045, df=2) and students' curiosity towards disabled people (F=3.137, p=0.047, df=2) depended on the length of the period of contact with disabled children in connection with the level of empathy.

In students' opinion, if the level of their empathy was high and the period of contact with disabled children was long, the ideal teacher of disabled children should have lower emotional distance to disabled children. However, when the level of empathy was low and the contact is long in students' opinion the ideal teacher should have high emotional distance.

Discussion

Keeping another person at an emotional distance, separating emotionally from him or her may be caused by the intellectual reflection on the situation of another person. As a result of intellectual processes: analysis, synthesis, comparison, assessment, etc. a person keeps emotionally distant from another person.

Sometimes the ability of emotional identification with another person requires some recognition of a situation of this person. This recognition may take some time and some patience of the part of the recognizing person.

The ability to distance oneself from feelings of other people, with the readiness to identify with them at the same time, need not be contradictory in itself. Correlating of these abilities with general intelligence of a person suggests that this kind of feelings can include intellectual reflection. As a result of this process in some situations a person agrees to his or her identification with another person, but in other situations (for example socially or ethically non-acceptable for this person) he or she keeps emotionally distant from another person.

People with low level of empathy are not sensitive to other people's feelings and they have a tendency to keep cool in social interactions so more frequently contacts with disabled people make them feel uncomfortable and endangered and they believe that the emotional distance to these children is needed. On other hand, students with high level of empathy during their contacts with disabled people learn how to identify their feelings, take into account their perspective, so more contacts with disabled children make these people more relaxed playing with children, and in their opinion high emotional distance is unnecessary.

Negative correlation between neuroticism and the ability of emotional control results from the essence of neuroticism. Neuroticism reduces one's abilities to control one's emotions. A person with a high level of neuroticism experiences anxiety and looks for some support from another person. Therefore such a person is more prone to the identification process with another person, because it gives him or her sense of security.

High level of neuroticism is also connected with low level of sensation - seeking (Strelau, 1985), so people with high level of neuroticism want to avoid social risk in many different social situations, though they have a great need for affiliation. People with high level of neuroticism require to be satisfied in their feelings of social security more than people with low level of neuroticism, so they would prefer the teacher who is able to identify with others' moods. Their opinion could reflect the projection of their own needs.

A closer and longer contact with disabled children gives one the opportunity to get acquainted with their lives, their specific needs, and consequently can facilitate the development of positive emotions towards them. It can also reduce anxiety, which may appear in contacts with these people.

The ANOVA results confirm once more the fact that a higher level of empathy and a longer period of contact with disabled children cause the shortening of the emotional distance between the children and their caretakers. Two variables: the level of empathy and the length of contact period with these children can have a positive influence on one another.

Conclusions

The results of our research allow us to say, that a multifaceted process of empathy is related to various elements of personality. Above all the results show the relations among empathy, prosocial attitudes and a level of neuroticism and general intelligence as represented by the students of special education.

These results indicate that empathy is a very complicated, holistic process. In addition they show the existence of certain , at least partly related, mechanisms between empathy and other elements of personality.

On the basis of our results we can say that the development of empathetic abilities, especially useful in the work of teachers of disabled children can be obtained by influencing prosocial attitudes of teachers of disabled children, as well as reducing their level of neuroticism and raising their intellectual abilities.

Our study brought us to the following, particular conclusions:

1. We have found significant differences in the students' prosocial attitudes connected with the length of the period of their contact with disabled children and the level of their's empathy.
2. It was turned out that the level of emotional empathy in interaction with the length of the period of contact with disabled children influenced the level of curiosity towards disabled people and the opinion that the ideal teacher should keep emotional distance to disabled children.
3. According to the results of many studies and our own results, empathy has significant influence on prosocial attitudes. It is very important for students' education and their future work to develop their empathy. The empathetic tendency in relation to other people seems to be a good predictor for the future occupation as a teacher of disabled children. This problem is being tested in our longitudinal study but we have to wait for a long time for the results.
4. Education for empathy and prosociability should be emphasized more in educational work with students. During the training in psychology we should utilize music and art as techniques developing imagination and emotional experiences (Kalliopuska, Ruokonen 1986). It will help our students to learn how to perceive sensitively the emotions of their own and those of other people.
5. Judging by our results we have found that counselling would be very useful for our students to help them choose the best future occupation in agreement with their abilities.
6. Students of the Special Education showed high prosocial attitudes towards disabled people. Our farther study based on projective methods and experiments will allow us to decide whether these attitudes are only declarative or connected with prosocial behaviours.

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International Journal of Special Education
1994, Vol. 9, No. 1

THEORY AND PRACTICE OF FUNCTIONAL RELAXATION

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When I was a student I worked for the SOS children villages. Originally these villages were meant to be a place for orphans, but later more and more mildly physically and psychicogically handicapped children were integrated.

In one of these villages lived Charly. He was the son of a white mother and a black father. With his dark skin Charly looked different from the other children, but he behaved and dressed like them. He wore short leather trousers and spoke the local dialect of this area in Tyrol. People found that funny and he himself laughed very often at it. But deep inside he hid feelings of sadness and confusion. And one day Charly stopped his struggle for identity and he committed suicide.

What I learned from Charly and other children in the SOS children villages was a better and deeper understanding of social influences on the development of human beings and I began to recognize how past and present relationships affect experience and behavior.

A more theoretical base for these ideas I found in Adlerian psychology. I had decided to go to Vienna and started to work as a psychologist at the Department of Child Neuropsychiatry at the University of Vienna. Marta Kos-Robes became my teacher in child and adolescent psychotherapy. She was an Adlerian as many other colleagues at this clinic. So I was stimulated to study Adlerian Psychology in theory and practice. I learned of the special meaning of social interest (Adler, 1929) for a single person as well as the society. Moreover I learned to understand life style (Adler, 1928/1973) as the organizer of sensing, feeling, thinking and behaving. And I began to recognize how somatic processes affect the mind and vice versa. But I still went on using exclusively psychotherapy in the treatment of patients until I met Marianne Fuchs. She invited me to take part in a workshop on *Functional Relaxation*. This was the start of an intense occupation with Functional Relaxation in theory and practice. I found the link I had missed between mind and environment, that is the body and I went on recognizing that a human being should be understood as a bio-psycho-social unit (Fig. 1).

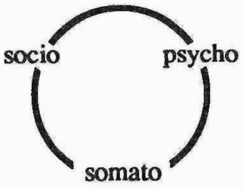

Figure 1. Bio-psycho-social Unit.

Definition of Functional Relaxation

Functional Relaxation is a somatic treatment concept, rooted in depth psychology (Fuchs, 1989).

Moreover it seems to be possible to develop a treatment concept integrating analytic psychotherapy and movement therapy (Reinelt & Gerber, 1991).

The Development of Functional Relaxation

In the fourties, one of Marianne Fuchs' children developed intractable spastic bronchitis which threatened to progress to asthma. As medicines did not help, Fuchs began to look for other ways to cure her child. Placing her hands on her child's chest, she *accompanied* the baby's respiratory movements and particularly concentrated on the retraction of the rib cage during exhalation, hoping that by supporting the expiratory movements she would *coax* the child into exhaling more deeply.

As an additional support, she uttered onomatopoietic sounds. Little by little the child learned to do what *helping mom* had done for him. Imitating the low-key sounds such as the mother had uttered, he learned more and more to let go and relax his chest muscles.

Working with her child in that way, Fuchs started to conceptualize *Functional Relaxation* (1974/1989). In this concept she combined her experiences in kinesiotherapy (Gönther's school) and breathing exercises (Schlaffhorst-Anderson) with her sound understanding of psycho-dynamic and psychosomatic conditions, which she acquired as a fellow at the Marburg University psychiatric department from Ernst Kretchmer and Friedrich Mauz. Moving to Heidelberg, she was given extensive support and encouragement by Richard Siebeck, then director of the medical department, and Victor von Weizséker, the founder of Anthropologic Medicine (v. Weizséker, 1951, 1955). As Siebeck shared her interest in autonomous somatic functions in health and disease, Marianne Fuchs found ideal conditions for defining the basic elements of her psychosomatic treatment concept. The image of man intrinsic to her concept and her understanding of the relationships between body and soul were largely derived from her studies of von Weizséker's scientific work.

In 1986 a group of researchers gathered around Marianne Fuchs and Thure von Uexöll. Studying experiences of *subjective anatomy* by Functional Relaxation, they started to elaborate the theoretical concepts of Functional Relaxation and their verbal presentation. Following up earlier studies, the group also examined theories of psychoanalysis and instructions for their usefulness in the context of Functional Relaxation (Fuchs, 1988, 1989; Johnen & Möller- Braunschweig, 1989; Klotz-Wiesenhötter, 1982). For the first time, Adlerian ideas of the interrelation between body and soul, which contributed much to psychosomatic medicine, were integrated into the concept of Functional Relaxation and, based on the case of an asthmatic, an attempt was made to describe how perceived somatic sensations related to biographically important emotions, ideas and thoughts and vice versa (Reinelt & Gerber, 1991). Bio-psycho-social activity patterns and organizers are now dealt with in a manner which reflects the close interdependence of somatic, psychic and social factors in the process of development (Reinelt, 1992).

Some Notes on the Concept of What Constitutes A Human Being in Functional Relaxation

Functional Relaxation is a body orientated therapy based on depth psychology. The practicioners in this field feel bound by an understanding of what a human being is, which is close to that of Adlerian Psychology, paying attention to the whole person, body and mind. Each part of this psycho-somatic unit is seen as relating to all the other parts and as being a meaningful component of the whole. The understanding of the relationship between body and mind is especially based on Weizséker's scientific work. The gestaltkreis-like interrelations between perception and motion, the body's stewardship of the soul and vice versa, the changing manifestations of a problem in terms of a shift between levels, the shift in emphasis from a mainly symptom-oriented approach to an approach centered around the suffering individual all are basic tenets of the therapeutic concept. The understanding of a human being includes also a depth-psychology-oriented dimension, concerning everything we cannot perceive or what we have not perceived (yet). The unconscious is not only a dimension of the psyche, but is continued in the body. Special attention and respect is given to what is going on autonomously and dynamically. We are moved and we move ourselves. We are not existing like independent monads, we need oxygen, water, food ... and excrete carbon, urine, sweat, faeces. Already on the biological level of our existence we stand in constant interchange with and in relationship to the environment. Our sense-organs are *relation-organs*. We need other human beings in order to become human ourselves. Therefore, everything is directed at interchange. The relationship between a person and the environment can be described by the model of the *function-cycle* (Funktionskreis) of J. Uexköll (T. v. Uexköll, 1981), *gestalt-cycle* (Gestaltkreis; Wiesenhötter, 1940/1989), and *situation-cycle* (Situationskreis; T. v. Uexköll, 1981). The capacity of the human being for dialogue is on one hand presupposed, and is on the other hand further developed in the therapeutic interaction with the patient, a process not only happening on a verbal level.

Additional Remarks on Body-Mind-Environment-Relationship

Studying the history of Functional Relaxation we can outline how the concept of body-mind-relationship altered.

In the early forties the body-mind-relationship was nearly not recognized. Functional Relaxation as a treatment concept linked the kinesthetic system and vegetative activities (Fig. 2).

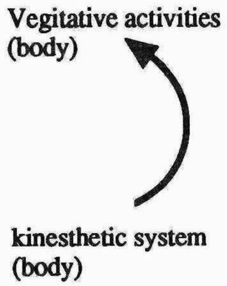

Figure 2. Kinesthetic and Vegetative Activities.

With the theory of the gestalt-circle (Wiesenhötter, 1940/1989) Fuchs found a concept which links movement and perception, body and mind. They belong together as two sides of one process (fig. 3).

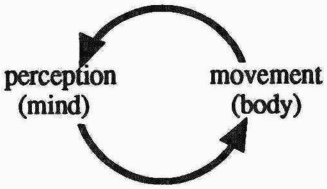

Figure 3. Linkage of Perception and Movement.

Moreover Weizsécker describes the change in the expression of unsolved problems. For example an unbearable social problem may find it's expression in a somatic symptom and vice versa (fig. 4).

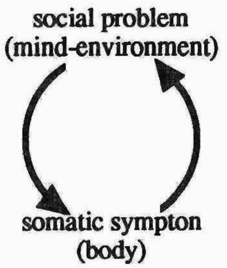

Figure 4. Linkage ofUnsolved Soial Problems and the Body.

Perception is a psychic activity related to physical activity. By directing our attention to physical movements we can sense them. They do not only stimulate unconscious organ processes but also conscious psychic activity. Moreover a human being acts as a psychosomatic unit which interacts with the environment (fig. 5).

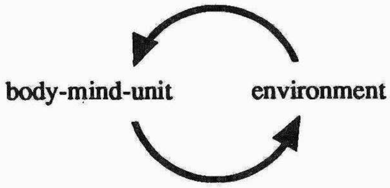

Figure 5. Interaction Between the Human Being and the Environment.

The Basics of Practical Work

During functional relaxation the patient primarily learns to perceive changes in pressure and tension in an ever more subtle way. Such changes in pressure and tension are due to both active movements and the rhythmic activity of the body in synchrony with breathing. During treatment perception, motion and (respiratory) rhythm are coordinated. Example:

The patient softly moves his/her shoulder joint at low force. The movement begins and ends with expiration. While performing this movement, the patient concentrates on the changes in pressure and tension in the shoulder joint, which are perceived as tactile and kinesthetic signals. These perceived signals (from the shoulder joint) are recaptured once the intentional movement is completed (Fig. 6).

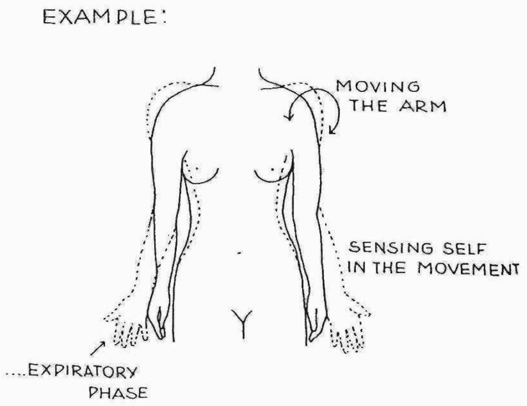

Figure 6. Changes in Pressure and Tension.

The *Rules of the Game*:

Functional relaxation does not work with fixed programs. It involves playful activities designed to make the subject aware of what is going on in his/her body. It is not geared to improving physical fitness and performance by standardized exercises. Sensing changes in pressure and tension during joint movements, becoming aware of the boundaries and *spaces* in one's body follow certain rules which leave ample scope for individual creativity in exploring perceivable bodily phenomena.

Rule no 1: Become aware of and feel whatever is going on during relaxing movements (during expiration).

Rule no 2: Once the movement (e.g. in the shoulder joint) has been completed, recapture at rest what it felt like.

Rule no 3: Do not repeat the exercise more than two or three times in a given part of the body (*Less is more*).

Effects of Functional Relaxation:

The playful activity the subject engages in during Functional Relaxation has multiple effects:

(1) It stimulates diaphragmatic activity and related somatic processes.

(2) It refines the perception of bodily pressures and tensions and makes the subject aware of the intrinsic dynamism, both active and passive, of his/her body (*dynamic bodily self*; see also Reinelt, 1985).

(3) It resolves untoward non-physiologic muscle contractions, harmonizes and stabilizes autonomous nervous processes.

(4) It modifies and resets psycho-emotional patterns and their somatic manifestations.

Indications:

Psychosomatic illnesses and troubles, neurovegetative failures, behavioural disturbances, disturbances of perception (which show their influence among others on problem-solving and school matters), disturbances of rhythm, disturbances of speech, etc.

Case Study

The patient, a young man, has been suffering from asthma with daily attacks since his second year of life.

In the second session, when he was searching to capture the physical sensations relating to his sitting posture, he had a significant experience: He recognized that he kept his shoulders pulled upwards and commented on it by exclaming: *Aha, I protect myself!* adding after a thoughtful interval: *I always do it that way*. In consequence of this process of experiencing and finding meaning for a moment he let go of his shoulders. Immediately afterwards he lifted his shoulders again. I encouraged him to let go of them once more, while perceiving and formulating the change simultaneously. In this and the following sessions he became again and again aware of the important meaning inherent in bodily movements. On one hand the patient found expression for something physical through language, on the other hand language became more intelligible through physical expression. The patient recognized that exhaling is not only a physical process of *coming to himself* in a downwards-inwards movement. He also found that in the internalizing and centering tendency inherent in exhalation, subtle bodily variations and differences can be perceived and remembered more clearly. He also recognized that during the phase of muscle relaxation (while exhaling) small movements are more supple and happen without drain. Through the growing coordination of perception, movement and rhythm the patient learned that he could activate himself without particular effort. Increasing sensibility and differentiation helped him to recognize any physical tension more distinctly. During the eleventh session he realized painfully: *I am permanently tense and stressed ... and as soon as my body starts to relax, I tense up again ... I am not allowed to feel good.* His physical well-being was connected with a sense of guilt and - in his imagination - with his demanding mother and grand-mother. They never allowed any free or creative play, but always set restrictions. During the following session physical discoveries became increasingly connected with phantasies, ideas, dreams, and memories.

Sensations were accompanied by psychic discoveries, and psychic aspects were experienced in the body. The *organ dialect* became more and more intelligible without ever being fully understood.

Existential themes pointed to a complementarity in the relationship of body and mind. They centered clearly around the themes of *loss of ego-consciousness*, *death*, and *fear of life*. In the 22nd session he reported the following dream: *... I see a living, flesh-coloured, moving corpse, who wants me to let him in. He is awfully frightening ...* . In the 37th session he formulated his relationship to death in a different, new way: *... Now I know, death frightens me less than life. I am condemned to live.* Fear to live and fear to die correlate with a restriction of the breathing rhythm. In the 38th session, when he experienced the rhythmical body movement of breathing in a resting position, he noticed for the first time that he could never allow the exhaling phase to end by itself. He explained that in the following way: *I fear that I won't come back anymore*. He believed that if he did not interrupt the exhaling process, he would not be able to inhale again and must die. At this point I offered him a new way of understanding. I told him that allowing himself to exhale naturally until it's coming to an end by itself, could also mean life. This was meant as a proposal to a new and different understanding. In order to give him the opportunity to experience that, I supported his breathing by placing my hands on the lowest bow of his ribs; thus supporting the downwards-inwards movement of his chest. The interpretation *to let go also means to live* and the supporting hands gave him trust enough to dare it. He found out that at the end of exhalation, after a little interval, the impulse to inhale occurs by itself without any conscious intention. Such experiences lasted only for a short time and needed frequent repetitions for him to learn to trust his autonomous bodily functions. Slowly he developed a sense of safety, which allowed repressed phantasies to come into consciousness. Thus, he remarked in the 40th session: *I have terrible phantasies: My flesh peels off the bones (the fear of losing ego consciousness?) ... there are fears of darkness and ghosts ... and I remember my childhood anxiety of being pushed out of my body*. Associations of significant experiences in the relationship to his mother and grandmother were following at this point: *They wanted to push something into me, something which I did not want to be*. Those psychic and physical phenomena point to a specific form of bio-psychic organization. This organization connects neurophysiological and psychic activities. Aspects of this superior organization can be found in physical movements, postures and processes, and in psychic phenomena. For our patient this complex organizes the bio-psychic representations of *fear of death*, *fear of life*, *fear of ego loss*, feelings of guilt when being well, indurations, blockages, and contractions in the areas of chest, belly, and pelvis ... They impair the free flow of the rhythm of breathing. Duration, blockage and contraction show the dilemma of the fear to live, the fear to die and to lose himself. It is not a coincidence that the words *fear* and *narrowness* (*Angst* und *Enge*) have one and the same root in the German language. The patient's *organ dialect* is a manifestation of the hopelessness of his situation, it shows the *blockages of original movements of life and self* (*Blockierungen originÑrer Lebens- und Selbstbewegungen*, Heisterkamp, 1990, p 86). On the physical level his symptoms reveal exactly that in an impressing way.

Some Further Remarks on Body-Mind-Relationship

This case history shows how social experiences have been influencing mind and body as well. They are inherent in physical and psychic activity. The work with the patient reveals a superior quality of organization which affects body, mind and interactions with the environment. A human being acts conscious and unconscious as a psycho-somatic unit (Fig. 7).

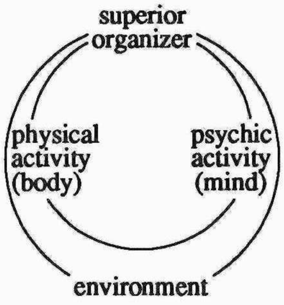

Figure 7. The Psycho-Somatic Unit.

This theoretical concept is the base for developing a more psycho-somatic oriented therapy. The results of combining movement therapy and analytic therapy are very promising. They support our efforts to go further in the development of a psycho-somatic way of therapy.

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International Journal of Special Education
1994,Vol. 9, No. 1

COMPARISON AND CONTRAST OF EDUCATIONAL SYSTEMS IN ENGLAND, IRELAND AND THE UNITED STATES IN RELATION TO VARIOUS CASE STUDIES

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Attention is being drawn to trisomy 13, Patau's Syndrome and trisomy 18, Edward's Syndrome, due to an increase in more sophisticated available diagnostic materials with the ability to detect these syndromes. Genetic testing is being done through various new techniques and procedures. Parents are now able to make decisions about their unborn child if early syndrome identification has been made. Unfortunately, many parents are given a poor prognosis and are told that their child will die within a year's time. The parents must deal with not only the fact that their child has trisomy 13/18 but also, that the child may not survive past a year. With proper guidance and support, parents are now able to investigate various educational and therapeutic services available for their child after his/her birth and early intervention can begin immediately. The authors' have researched various programs throughout the United States, England and Ireland suitable for children with trisomy 13/18. Documented cases throughout the article will show that children with trisomy 13/18 do survive well beyond a year and can be educated. Doctors often misinform patients about these children without further investigating the facts concerning programs and services available. Because physicians tell parents that their child will not survive, parents are left with no hope and no information about programs that could stimulate and enrich their child's life.

Pre-Natal Diagnosis of Trisomy 13/18 Children

More families have been affected by a chromosomal abnormality than is realized. About 50% of pregnancies miscarry within days of conception, and one in five confirmed pregnancies end naturally before twelve weeks. Trisomy 13/18 occurs in 1 in 1,800 live births which makes them as common as cystic fibrosis and more frequent than the most common type of muscular dystrophy, Duchenne. Various techniques and testing procedures have become available in order for early detection of a variety of chromosomal abnormalities, thus giving parents the opportunity to make choices about their unborn child.

The prenatal diagnosis of babies suffering from these syndromes is expected to increase as the following tests and procedures become more widely available to pregnant women:

a) *Chorion Villus Sampling* also known as CVS can be performed at ten to twelve weeks of pregnancy, and depending on the sample and the laboratory technique used, a result may be available within a matter of days; some cases can take up to four weeks.

b) *Amniocentesis* is performed at sixteen weeks of pregnancy in most cases and results can take two to four weeks. This procedure reveals whether an unborn child is suffering from a chromosomal abnormality.

c) *Maternal Serum Screening Test* is a blood test that can aid in the detection of Down's Syndrome, some cases of trisomy 13/18, and neural tube defects such as spina bifida and anacephaly. The test, usually carried out about the sixteenth week of pregnancy, identifies women with an increased risk of having a baby with these conditions.

d) *Routine Scans* such as *ultrasonography* cannot specifically diagnose chromosome abnormalities; an invasive investigation is necessary for this. However, some centers are now able to pick up ultrasound *markers* for abnormalities associated with trisomy 13/18 on a routine ultrasound. For example, in some cases kidney and heart abnormalities have been detected by the scanning process. The ultrasound scan can be done at sixteen to twenty weeks of pregnancy.

According to the latest reports it could soon become routine to look for cleft lip, sometimes associated with chromosomal abnormalities, which in turn means amniocentesis may be more commonly offered to younger women, leading to an increase in prenatal diagnosis of trisomies.

Trisomy 12, Patau's Syndrome Characteristics

Trisomy 13/18 occurs in 1 in 1,800 births. The children are born very small, with low birth weight, and frequently multiple organ malformations. Surviving babies may suffer severe mental retardation, with additional eye, heart, limb and white cell difficulties. The physical features have a variety of distortions including: the closeness of the eyes, shape of the fingers, polydactyly (number of fingers), and reduced growth. Medical problems include: apnea, spells of interrupted breathing, deafness, small cranium, moderate microcephaly with sloping forehead, minor motor seizures, protrusion of the spinal cord, cleft lip and/or cleft palate, low set ears, skin defects on the scalp, mild seizures, and severe failure to thrive. (Widerstrom, Mowder, and Sandall, 1991)

Trisomy 13 Case Studies

In Ireland, Aine, is a five year eight month old child with full trisomy 13, diagnosed at birth through chromosomal testing. Her manifestations include: 1 small extra digit, scalp defect, apnea seizures and poor muscle tone. Aine attends a special school four hours daily. A team cooperates with a psychologist in administering tests to determine the severity of her handicap. The school administers additional tests to determine the type of teaching strategies which would benefit Aine best. Aine understands a few simple commands like, *Here's your bottle* and *up*. She can pull herself to a semi-sitting position. In addition, a team approach also provides Aine with physical, occupational and speech therapy during the week. Without these interventions, Aine would not lead the fulfilled life she does. Her mother replied, *Stimulation is the key to a better life for these children, without stimulation many would cease to be.*

In England, John, is a four year old male diagnosed with trisomy 13 at birth through a chromosome count. John is microcephalic, has low set ears, epileptic fits, small eyes, is blind, has rocker-bottom feet, extra digits a degree of cerebral palsy, small external genitalia and undescended testes. He has had two hernia operations and is prone to urinary infections. John attends a special school through the local education authority. A portage provides play including computers and micro-touch switched toys. Additionally, home visiting physical therapist has visited him since he was six weeks old and comes once a week to help John with social help counseling, social interaction with his peers. Through John's various types of early intervention strategies he is now able to hold up his head, stand with support, drink from a straw, and roll from side to side. He is much more aware of his environment, parents, siblings and friends.

In the United States, William, lived 3.4 years. He was born by cesarean section weighing eight pounds at birth, his mother's biggest baby. William's mother went through routine prenatal care and there were no signs of anything extraordinary. He was born with a high forehead, low set ears in which the helices overlapped, and an extra digit on his left hand. His left hand also had no bone and soon came off. A CAT scan revealed a small right eye with no pupil. His left eye had a small cataract out of the line of vision. He had an abnormal whirl of hair over the posterior portion of his skull and three small scalp defects on the top of his skull. A week after his birth his parents brought him to the Waisman Center for a blood test which diagnosed him as a full trisomy 13 syndrome. The geneticist told his parents to take him home and love him since he did not have a long time to live. William was unable to tolerate some of the formulas which he was fed and at 3.6 weeks old he started to regurgitate gastric juices. Whenever William had surgery, the incisions did not heal well and his parents had to continuously adjust the dosage of the antibiotics. At ten months of age William was evaluated at a therapeutic learning center and found to have: Early-LAP scores of a two month level, fine motor skills at a four month level, language skills at a four month level, and self-help skills below a six month level. He played with his fingers, reached for objects, grasped and transferred toys from one hand to the other. William turned his head towards sounds, laughed aloud, and mouthed for toys. He started attending occupational and physical therapy approximately two to three times a week at 30 to 45 minutes per session. He soon started speech therapy on the same schedule.

At three years old his parents placed him in an early childhood public school program. William was walking with assistance and could walk for fifteen feet with a mini-walker while someone held the back of his shirt. He could say *ma-ma*, *da-da*, and *ba-ba*. He was starting to tolerate solid foods in small pieces. He could interact with the other children, and his mother said that *he was basically a very happy child.* He was assisted with an aid at all times. William was evaluated by a heart and eye specialist who diagnosed him with eye defects. An ultrasound of his heart revealed dextrocardia and thickened aortic valve. Due to additional problems with ears, mucous build-up and pneumonia, his cause of death was never determined. It is believed that he may have aspirated on some of his formula. His mother writes,

> Everything he had was very minor and it all functioned properly except for his brain. He was a very dynamic and happy boy and there was never a dull moment. He did not like to sleep much, but as he got older he started to sleep through the night. He made a great attempt to feed himself. He hated water and would only drink milk. He loved music, balloons, sunshine, and being around other children. There was a big growth spurt both mentally and physically just months before his death, so it makes me wonder just how far he would have gone.

Trisomy18

In England, Jonathan, is a four year six month old boy with trisomy 18 diagnosed five days after birth by a chromosome blood test. He was born with no heart or kidney defects but with dislocated hips and was fitted with a splint. From the very beginning he has had very good support from local doctors, physical therapists, health visitors and consultants. For the first few months of his life Jonathan was visited at home by various health care and educational consultants. A routine was settled upon and it was decided he would attend the Child Development Center (CDC) once a week for physical therapy and play therapy. Each of these sessions lasted approximately one hour.

Jonathan was not a happy infant and screamed with colic. He was a very slow feeder. At a year old he sat in a supportive corner seat with a tray in front of him and for the first time pushed a wibble/wobble toy by himself. He also began to eat pureed solid food which he did not like and began to have apnea attacks.

At two he was sitting up, attempting to crawl, was very happy and smiling, reaching out for objects, eating four pureed meals a day while attempting to hold a spoon. He drinks well from a beaker, sometimes holding it, and able to eat a whole chocolate button (like an M&M) and hold and eat a rusk (cookie). He enjoys rolling on the floor and sitting in a rifton chair with a tray filled with toys. A staffing, or statementing process, took place when Jonathan was two years nine months which identified strategies to be used with him during school hours. In addition, Jonathan attends a local respite facility one night a week to give his parents a night off. He has a much better sleeping pattern since attending school.

During 1990, a portage worker came once a week for an hours teaching session and Jonathan also participated in a one hour a week hydro-therapy session before his regular physical therapy and play therapy schedule was in effect. He now gets all of these therapies and activities at school.

Jonathan's greatest accomplishment so far is being able to stand with help and swing from side to side accompanied by squeals and smiles. He is also making walking movements, and if supported under the arms can walk about ten to fifteen feet although he still has no sense of balance. He rolls himself from side to side and is able to completely roll over and elevate his head for a few seconds and begins to roll back and forth again. He continues this pattern for a while and is quite content with the motion.

In the United States, Katie, is an eleven year old girl diagnosed with trisomy 18 at three days old. At three day old her prognosis, as most are told was that she would not survive past the first year of her life. As her condition stabilized and she approached her first birthday, her prognosis changed. She entered an early intervention program at the age of four months. She attended a part time program until she was four years old. She then entered the public school system where the initial individualized educational plan was taken from the data which had been logged thus far. She is presently in a fixed grade cluster and has been in the same class since the age of four.

Katie participates in a physical therapy program daily within a group situation. Standing activities are done to encourage transference of skills. Occupational and speech therapy are also given. Katie is very vocal and can say *mama* and *dada*. Her speech comes and goes. If she is learning a new task her speech is not as frequent as when the concentration is on her speech. She feeds herself pureed table food and also drinks on her own. The activities in school rotate every twenty minutes. The activities range from floor to standing vs. chair activity as well as going from group to individual activities. Her program was designed by both her teacher and physical therapist. She is limited to some activities because of her severe scoliosis. Her only other defects include a deformed heart which is upside down in her chest cavity and some upper respiratory problems which is her major medical complication in addition to the scoliosis.

Educational Management

A student should be viewed as an individual whose needs are met through careful planning, varied curriculum delivery and continued review. The processes are also enhanced by caring interpersonal relationships and a collegiate approach on policy, and all aspects of educating children with special needs. The curriculum should be viewed as a continuum, which can be assessed at any point, whenever needs arise and whenever appropriate. A school should take a broad view of a student's potential, and be careful not to restrict expectations which could lead to narrowing of the student's curriculum. Parental involvement is also an essential part of a team educative process. (Widerstrom, 1991)

Care as well as education is an important element of any school's provision. Teachers need to be skilled in providing programs which are based on learning through small steps to ensure progress and enable pupils to experience continual success and achievement. Support services should include speech therapy, occupational therapy and physical therapy with access to an educational psychologist who should visit the school periodically to review pupil progression. In addition, contact with social workers, a community mental health team and medical staff also need to be maintained.

Early intervention for a child identified with special needs should begin as early as the chromosomal abnormality has been identified. In the Blackmarston School, located in Herefordshire, England, children are enrolled as early as two years of age. Their belief is, *to provide a broad, balanced and relevant education for students within a caring and supportive environment.*

Classes should be small and under the guidance of a teacher helped by special support assistants. By having small groups and specially trained staff, educators are able to concentrate on the individual needs of pupils. Emphasis should be placed on fostering

links between home and school in order for educational staff and parents to work together for the benefit of the child. Progress of the pupils is monitored by the classroom teacher, and an educational psychologist assesses pupils and recommends educational needs, changes and other placements. Certain goals need to be recognized when setting up an educational program for children who are severely mentally handicapped. They should include:

1. To give children the skills and provide experiences for them to develop as *whole* people, having quality of life based on personal fulfillment.
2. To provide a wide range of real experiences both within and outside the school, that enable skills to be learned and practiced.
3. To enable children to achieve the maximum of their potential.
4. To enable children to be an accepted member of the community, this begins with the classroom.
5. To provide an environment which is conducive to learning.
6. To influence the environment outside school towards a greater understanding of the children's needs and abilities.

Conclusion

Networking of parents, physicians and educators in the developing area of trisomy 13, Patau's Syndrome, and trisomy 18, Edward's Syndrome, is the beginning of early intervention strategies. The sharing of information has begun with simple correspondence to and from parents and relatives. Networking also helps parents deal with issues such as: special education programs, legal rights of the handicapped, family unity, support for siblings, isolation from the community and sharing of the struggle for the survival of the infant. Through early intervention strategies these children can be further serviced in the school system.

Specific Conclusions

The authors make the following recommendation based on their research:

1. Continued work in early detection and diagnosis of trisomies 13/18.
2. Increased communication between physicians, parents and special needs facilities in order to promote a positive attitude for the diagnosed baby.
3. Increased public awareness and public education of the trisomy 13/18 child's potential for success.
4. Additional funding for programs to promote networking both nationally and internationally.

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Manuscripts should be sent to the member of the Editorial Board of the respective country for initial review.

SUBSCRIPTIONS AND CHANGE OF ADDRESS

The *International Journal of Special Education* (ISSN 0827 3383) is published twice a year, one volume per year.

Subscription rates per volume are $45.00 for institutions and $30.00 for individuals in Canada and the United States. An additional $1.00 for postage is charged for subscriptions in other parts of the world. Single and back issue copies, if available, are $7.00 each. Single copy orders must be prepaid.

Subscriptions and editorial correspondence should be addressed to the editor:

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Faculty of Education
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Printed by **The Original Printers Graphics Inc.**, Suite 129 - 470 Granville Street, Vancouver, B.C. V6C 1V5