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Note from the Editors

Welcome to the 2010 edition of *The Journal of the International Association of Special Education (JIASE)*. First, we feel honored and privileged to assume the editorship of this journal. It is a responsibility that we take with both humility and respect. Humility because this is the official journal of the International Association of Special Education whose mission includes “promoting professional exchange among special educators all over the world and encouraging international cooperation and collaborative international research.” It is humbling to be entrusted with the stewardship of such a grand mission. We take this with great respect for the sterling work of Greg Prater and his editorial team. During the time that Greg was editor, he did an outstanding job with the journal reaching out and working with prospective authors from around the world to produce a highly respectable and professional journal which our organization can be proud of. We say kudos to Greg and his dedicated editorial team as well as to the distinguished authors who continue to choose our journal as a medium to share their expertise with others who are also dedicated to serving individuals with exceptional needs around the world. We are fortunate that Greg will continue to provide leadership to the journal as associate editor along with Malgorzata (Gosia) Sekulowicz.

Next, accolades should also go to Jamie Timmerman for her service as managing editor. Jamie will continue to serve the journal as a consulting editor. Our new managing editor is Lawrence K. Ametepee. Lawrence is a doctoral student in the Department of Educational Psychology and Special Education at Southern Illinois University Carbondale (SIUC). He brings valuable international educational experience having worked in Africa and North America.

We would also want to express gratitude to the Department of Educational Psychology and Special Education at SIUC for the support they have provided to make the publication of this edition possible. Finally, many thanks to the Consulting Editors, authors, and all those who have made this publication possible.

This edition does not include a PRAXIS article. As Greg stated in a previous edition “the PRAXIS section of the journal is supposed to have immediate practical application for those providing direct services to individuals with disabilities.” We, therefore, encourage you to submit your ideas in manuscript form for consideration for publication in this section of future editions of the journal.

We look forward to the 12th Biennial Conference in Windhoek, Namibia, in 2011 and we hope to see you all there.

Sincerely,

Morgan Chitiyo, Editor

Lawrence K. Ametepee, Managing Editor

Assessing Needs and Challenges Reported by Caregivers and Teachers of Children with Autism Spectrum Disorders in China

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Abstract

The purpose of this study was to explore the needs and challenges reported by caregivers and teachers of children with autism spectrum disorders (ASD) in China. The study group consisted of a random sample of 108 caregivers and 98 teachers of children with ASD. Analysis of epidemiological data produced results consistent with those reported in the Western literature. Many Chinese children with ASD in this study lived with their extended families with support from older generations and the majority of the families had only one child. Financial factors were particularly important for both families and teachers. Limited professional training and social support were reported as barriers to a quality education for these children. Caregivers considered deteriorated family relationships as a predominant source of stress, whereas low employment salary and benefits appeared to be the main source of stress that diminished the teachers' commitment to educating children with special needs. Teachers with higher levels of education reported higher levels of dissatisfaction with employment salary, benefits, and home environment. In addition, the findings highlighted social-cultural influences on parenting stress and coping mechanisms.

Introduction about Autism Spectrum Disorders in China

Although much has been written about the education and family life of children with Autism Spectrum Disorders (ASD) in countries such as the United States (U.S.), little is known about this disorder in the People's Republic of China. ASD is a complex developmental disorder that is characterized by severe impairment in several areas of functioning including communication, behavior, and socialization, and it occurs in

all social, racial, and ethnic groups (Autism Society of America, 2002). The challenges involved in raising a child with ASD have been well-documented in Western societies during the past several decades. However, minimal research has been conducted in China so that there is limited knowledge about the needs and challenges reported by Chinese caregivers and teachers of children with ASD.

A major reason for studying the effects of ASD in families and educational settings is the rapidly increasing prevalence of this disorder, which puts an enormous strain on educational resources and takes a tremendous toll on families (Autism

Society of America, 2002). As families of children with ASD deal with their children's unusual behaviors, they experience a sense of loss and rarely report moments of family connectedness (Werner, 2001). Similarly, increasing numbers of children with ASD in the schools are an additional source of stress for the teachers serving the special education population. These stress factors include increased workload, more demands involving behavioral management and parent-teacher communication, and slower progress because of the students' deficits (Farber, 1991).

Financial concerns are another major contributor to the stress experienced by families and teachers of children with ASD. It has been estimated that the cost of raising a child with a disability is approximately three times greater than the cost of raising a typically developing child (Jarbrink, Fombonne, & Knapp, 2003). Costs to the family may include difficulties maintaining employment, fewer resources for other children in the family, and difficulty finding and paying for child care. Chinese special education teachers are paid at a lower base rate than teachers employed in regular education settings (Ding, Gerken, Van Dyke, & Xiao, 2006). Additional stressors for special education teachers include increased workload and more time spent on behavioral management (Farber, 1991). Increased workload coupled with lower salaries may diminish teachers' motivation to continue to work with children with special needs (Ding et al., 2006).

Lack of professional training and social support is a third major stressor and may be unique to the special education system in China. The stress reduction ameliorating effect of social support has been well documented in the literature (e.g., Boyce, Behl, Mortensen, & Akers, 1991; Byrne & Cunningham, 1985; Johnson & Sarason, 1978). Mothers of children with ASD experienced the least stress when they received the greatest amount of support (Bristol, 1984). Support from professionals helps to improve the parents' adaptation to having a child with ASD (e.g., Farran & Sparling, 1988). Differences in the receipt of formal services have been correlated with differing levels of stress in the families of children with ASD (Bristol, 1984). Although in Western societies, ASD is a well-known developmental disorder, it is relatively new to Chinese society. Not until 1984 was the concept of autism introduced in China, which was more than four decades after Kanner's (1943) initial report. Formal services for children with ASD in China are not comparable to those provided in the U.S. or other Western countries.

Although special education services are familiar to the U.S. public, the special education system in China presents a very different picture. In the U.S., public schools, private schools, and parochial schools admit students with disabilities. In China, students receive either public education or private education; there are no parochial schools. Public education in China is provided in two types of schools: regular schools and special schools. Special schools in China primarily admit three categories of disabilities: intellectual disabilities, blindness or visual impairment, and deafness or hearing impairment.

Special schools are designed specifically to educate these children, who are physically segregated from their peers without disabilities. There is no public education in China specifically designed for children with ASD, and they are often grouped with children with intellectual disabilities (e.g., children with Down syndrome) if they attend public special schools. The general education system in China typically does not admit children with severe disabilities primarily due to the large teacher-student ratio (which ranged from 1:30 to 1:50 in one classroom with one teacher without a teacher's aide). Typically, there are no resource rooms or special education classrooms embedded within regular education schools. Children with severe disabilities would be considered "Dawdling in Regular Classrooms," that is, children with special needs sit in a 50-student classroom without receiving appropriate education and without one-on-one support (Ding, Yang, Xiao, & Van Dyke, 2008). As a result, Chinese children with ASD do not fit into either the public general education system or the special education system because of lack of eligible teaching personnel with adequate training. Thus, private education often becomes a necessary solution for children with ASD, which results in an increased financial burden on the families in China.

Occupational stress among special education teachers has gained increased attention. The endpoint in the process of coping unsuccessfully with chronic stress is burnout (Cherniss, 1995; Farber, 1991). Although all teachers experience stress, special education teachers may suffer additional stress (Farber, 1991). Stress factors include increased workload, management of problem behaviors, more effortful parent-teacher communication, and slower progress of their students (Jennett, Harris, & Mesibov, 2003). A unique set of cognitive and behavioral characteristics of children with ASD set them apart from other children with special needs. These characteristics might include impaired communication, lack of reciprocal social interaction, and a wide range of challenging behaviors (American Psychiatric Association, 2000). Professionals who work with difficult clients and do not feel competent may be at greater risk for burnout (Jennett et al., 2003). Cherniss (1995) recommended adequate training or training in innovative techniques to increase feelings of competence and foster effective coping mechanisms for providers.

The purpose of this study was to explore the needs and challenges reported by caregivers and teachers working with children with ASD in China. This study posed several research questions. First, were some of the demographic findings in Chinese families of children with ASD unique to the Chinese culture, such as the family structure and the number of children in the family? Second, did the financial factors impose an extra burden on these families and also play an important role in special education teachers' level of commitment to their profession? Third, were the professional training and social support in China limited, given the fact that knowledge regarding ASD is relatively new to Chinese

society? Finally, were some of the sources of stress reported by caregivers and teachers unique to Chinese culture?

Method

Participants and Settings

Participants in this study were 108 caregivers of children with ASD and 98 teachers of children with ASD from 10 randomly selected urban special schools or training facilities in China. All participants were volunteers after being informed of the purposes of the study. Among the 10 sites, three were located in northern China (Beijing, Tianjian), three were in southern China (Haikou, Guangzhou, Zhuzhou), two were in western China (Xi'an, Lanzhou), and two were in mid-eastern China (Quanzhou, Jiujiang). Because most schools or training facilities for ASD were located in metropolitan areas in China, all selected sites were in urban areas.

Instruments and Procedures

To develop the study questionnaires, semi-structured interviews were conducted with five teachers and two parents. Major concerns were summarized based on these interviews. The investigators developed two separate sets of questionnaires. Some questions were similar in both questionnaires and some questions were unique for caregivers or teachers. In addition, questionnaires were field tested by two teachers and two parents. Critical reviews of the questionnaires were completed by three experts with backgrounds in special education and school psychology.

The major domains measured in the caregiver questionnaire included (a) demographic information, (b) caregivers' perceptions of the education received by their child, (c) caregiver-teacher communication, and (d) sources of stress in the family. The domains measured in the teachers' questionnaire were (a) demographic information, (b) salary and benefits, (c) training background and access to professional training, (d) caregiver-teacher communication, and (e) sources of stress at work. Packets of questionnaires were mailed or given to the volunteer teacher coordinators in the schools with a cover letter explaining the rationale for the study. The parents and caregivers who completed the questionnaires were asked to return the questionnaires to the volunteer coordinators at each site. All questionnaires were mailed to the investigators.

Results

Characteristics of the Participants

Of the caregiver participants, 90.8% were either mothers or fathers of a child with ASD and less than 10% were grandparents and others (e.g., relatives). The educational level of 69.4% of the caregiver participants was at or below an

associate degree. The majority of the families (88.6%) had monthly incomes that were at or below 5000 RMB (Chinese currency; approximately 740 USD). The majority of children with ASD were from 2 to 14 years old with an average age of 5.4 years, and 89.8% were males. Of the children in the families surveyed, 77.8% were diagnosed with autism and the others had an autism-related diagnosis (e.g., Asperger's syndrome, autism-like characteristics). The mean age of diagnosis was 3 years. Approximately half of the children (47.7%) were verbal and the other half (52.3%) were non-verbal. More than half (54.6%) of the families were nuclear families (i.e., father, mother, and child), 42.6% were extended families, and only 2.8% were single-parent families. Less than one fifth (19.4%) of the families had other children in addition to the child with ASD. Of the 21 families with a second child, a sibling in one of the families also had ASD (5%).

Among the teacher participants, 83.3% worked with children 7 years old or younger, and 16.7% worked with school-aged children (8-18 years). All 98 teachers surveyed were employed by private schools or training facilities. In terms of education degrees, half of the teachers (51%) had vocational training or high school diplomas, 38.5% had associate degrees, and only 10.4% had bachelor degrees or higher. In terms of educational background, 27.6% were from social work, 16.3% from preschool education, 2% from medicine-related professions (e.g., nursing), 21.4% from general education, 16.3% from special education, 19.4% from other fields, and 21.4% had no professional training in any specialty area after high school. With respect to special education training, 2.1% obtained training in vocational schools, 10.3% received training in college programs, 73.2% attended short-term training, 17.5% completed training classes, and 6.2% did not receive any training related to special education. Approximately 90% of the teachers surveyed received a monthly salary at or below 1,500 RMB (approximately 222 USD).

The majority of the teachers (92.6%) were not sponsored by their employers for their residency in the cities in which they resided, which meant they had to live as non-residents. Individuals living as non-residents in a city in China may be subject to a higher cost of living for public services in comparison to local residents. Teachers in public schools sometimes receive minor holiday rewards from the local Ministry of Education. In this study, none of the teachers received minor rewards offered by the local government. All teachers hired by public schools in China have medical insurance sponsored by local government. In this study, 72.4% of the teachers did not have medical insurance. Among the 27 teachers who had medical insurance, one was self-insured, 21 had insurance sponsored by the schools, 4 had medical insurance through other venues, and 1 did not provide information regarding medical insurance.

Education Provided for Children with ASD

Among the children surveyed, 8.6% were educated in public regular schools, 8.6% in public special schools, 75.2% in private schools, and 5.7% in home schools, and 1.9% did not receive any formal education. More than one fourth (27.4%) of the children received services outside of the schools. For children enrolled in public schools, the mean educational cost to the families was 653 RMB (97 USD) per month, whereas the cost was 1,715 RMB (254 USD) per month for those enrolled in private schools. About one third (37.4%) of the caregivers were satisfied with the education of their children, about one third (36.4%) provided neutral comments, and about one quarter (26.2%) were unsatisfied.

Caregiver-Teacher Communication

Degrees of satisfaction of caregivers toward communication are presented in Table 1. More than half of

the caregivers (61.3%) and the teachers (72.9%) were satisfied with parent-teacher communication. About one third of the caregivers and one fifth of the teachers held a neutral stance. A small portion of the caregivers (7.5%) and teachers (6.3%) were unsatisfied with caregiver-teacher communication. The Chi-Square test result showed that the distribution of caregivers' satisfaction with parent-teacher communication was not significantly different from the teachers' report. Caregivers with higher education levels tended to have higher incomes. However, neither education background nor income of caregivers was significantly correlated with degree of satisfaction with caregiver-teacher communication or frequency of communication. A higher degree of dissatisfaction of caregivers was positively correlated with less frequent communication (see Table 2). Face-to-face communication was most popular (91.3%) among the caregivers.

Table 1

Caregiver-Teacher Communication

	<u>Degrees of Satisfaction</u>			<u>Frequency of Communication</u>			<u>Methods of Communication</u>	
	C	T		C	T		C	T
Very Satisfied	6.6%	8.3%	Daily	44.7%	71.0%	Face-to-face	91.3%	100.0%
Satisfied	54.7%	64.6%	Weekly	39.8%	20.4%	Phone	11.5%	20.0%
Neutral	31.1%	20.8%	Biweekly	4.9%	3.2%	Notebook	19.2%	43.2%
Unsatisfied	7.5%	6.3%	Monthly	4.9%	3.2%	Emails	1.0%	6.3%
Very Unsatisfied	0.0%	0.0%	Once/semester	2.9%	0.0%	Others	1.0%	3.2%
			No communication	2.9%	2.2%			
	Pearson Chi-square:			Pearson Chi-square:				
	.407			.005**				

*Note. C=caregivers, T=teachers; * p<.05; ** p<.01; *** p<.001"*

Table 2

Correlations between Caregiver Income/Education and Measures of Child Education, Caregiver-Teacher Communication, and Perceived Impact on Sociability

Caregivers	1	2	3	4	5	6
1. Education	–	.424**	-.057	.026	-.032	.084
2. Income	–	–	.052	-.175	-.169	.050
3. Satisfaction toward School Education	–	–	–	.175	-.038	-.096
4. Degrees of Dissatisfaction	–	–	–	–	.387**	-.080
5. Frequency of Communication	–	–	–	–	–	-.042
6. Impact on Sociability with Friends	–	–	–	–	–	–

Note. The weights of satisfaction were defined as 1 for “very satisfied” to 5 for “very unsatisfied.” The weights of frequency of communication were defined as 1 for “daily communication” to 5 for “no communication.” The weights of impact on sociality in friends were defined as 1 for “significant impact,” 2 for “some impact,” and 3 for “no impact.”; * $p < .05$; ** $p < .01$; *** $p < .001$

The majority (71%) of the teachers had daily communication with caregivers, whereas only 44.7% of the caregivers reported daily communication with teachers. The details of the frequency of caregiver-teacher communication were presented in Table 1. The Chi-Square test result showed that the distribution of frequency of caregiver-teacher communication reported by caregivers was significantly different from teacher report ($\chi^2=16.69$, $p=.005^{**}$). Neither the levels of teacher education received nor the monthly income were significantly correlated with degree of teacher dissatisfaction with communication or frequency of communication (see Table 3). Similar to the caregivers, all teachers (100%) preferred face-to-face communication.

Of the caregiver participants, the majority (73.1%) reported that the teachers of their children had received education specific to ASD. Almost one-third of caregivers (32.4%) reported that teachers participated in professional conferences regarding ASD. About half (56.2%) reported that teachers received in-service training, and 9.5% reported that teachers did not receive relevant training of ASD. In terms of additional educational training of children outside of school, 34% of the caregivers reported that their children did not receive additional training. Among the children (34%) who received extra training, 30.1% received communication training, 45.6% received sensory-motor training, and 12.6% received other types of training. Only 9.4% reported that their children received services from professionals other than teachers. To obtain information regarding resources for ASD, 64.5% of the caregivers used the Internet for information, 63.6% relied on other parents, 37.4% relied on schools and

teachers, 33.6% relied on medical personnel, and 0.9% relied on community resources.

Table 3

Correlations between Teacher Income, Education, Levels of Dissatisfaction, and Frequency of Communication

Teachers	1	2	3	4
1. Income	–	-.116	.128	.256*
2. Degrees of Dissatisfaction	–	–	.141	.132
3. Frequency of Communication	–	–	–	-.039
4. Educational Level	–	–	–	–

Note. The weights of satisfaction were defined as 1 for “very satisfied” to 5 for “very unsatisfied.” The weights of frequency of communication were defined as 1 for “daily” to 5 for “no communication”; * $p < .05$; ** $p < .01$; *** $p < .001$

Workload, Relevant Professional Training, and Support

Among the teacher participants, each teacher averaged 8.3 working hours per day with a mean of 5 students with ASD. The mean paid vocational days were 17 per year. The majority of the teachers (92.9%) had a teacher’s aide. The majority of the teachers (92.9%) had regular meetings with colleagues and administrators to discuss teaching-related issues. In terms of relevant training received, 83.2% of the teachers reported

trainings provided by school administrators, 57.9% reported trainings embedded in regular school meetings, 50.5% had trainings through communication and in-service trainings held in schools, 30.5% had training through conference programs, and 8.4% of teachers attended a college or university for professional training. The content of training included applied behavior analysis (ABA) teaching methods (89.5%), psychology (36.8%), TEACCH (Treatment and Education of Autistic and Related Communication Handicapped Children) (34.7%), sensory motor integration (12.6%), auditory integration (12.5%), social welfare (5.3%), and others (26.3%). When asked whether they “received any training relevant to psychology,” 49.5% of the teachers reported not having received psychology-related training.

Both caregivers and teachers were asked to rank the order (i.e., from 1 to 6) of possible solutions to improve professional training and social support in order to enhance education for children with ASD (see Table 4). Both caregivers and teachers ranked “there is a need to have more relevant books and assistive technology” as the first solution. Teachers ranked “salary for teachers should be increased” as the second solution. Caregivers ranked “parent organization should have more impact in the society” as the second solution, whereas teachers ranked this item as the fourth solution. Both caregivers and teachers ranked “schools and medical systems should provide more information to parents and teachers” as the third solution.

Individualized Education Plan (IEP)

A majority of the caregivers (75.2%) reported that their children had an Individualized Education Plan (IEP) in school, whereas only 32.4% reported that they participated in the process of developing an IEP for their children. Among the children who had an IEP, about 76.5% of the children’s caregivers reported that the IEPs were actually implemented. A slightly higher percentage (87.4%) of teachers reported that their students had IEPs. For those who had IEPs, 97.6% of the teachers reported that the IEPs were actually implemented.

Reported Parenting Stress

A majority of the caregivers (88.8%) surveyed reported that they were able to accept the diagnosis of ASD. However, 49.1% reported that there were still family members who could not accept an ASD diagnosis. The mean amount of time for caregivers to emotionally accept their child’s diagnosis was about 1.32 years. When caregivers were asked to rank the order of factors triggering parenting stress (see Table 5), the number one factor was “family relations are deteriorating due to child’s disability.” The item “the child cannot take care of parents in the future and we are wondering about having a second child” was ranked the number two factor, followed by “personal career is impacted by the child’s disability.” Only 8.6% of the caregivers reported that their child’s disability had “significantly impacted” the degree of sociability in their

social life, 52.4% reported “some impact,” and 39% reported “little impact.” Caregivers’ educational background and income did not correlate significantly with sociability in their social lives (see Table 2). Only 18.9% of the caregivers indicated that they had concrete and clear plans for their children’s future.

Table 4

Possible Solutions to Improve Quality of Education for Children with ASD

<u>Items</u>	<u>Caregivers</u> Mean/SD	<u>Teachers</u> Mean/SD
Autism should be recognized as a disability by government and be provided with mandatory education.	5.34/1.380	5.31/1.386
Teacher training in ASD education should be enhanced and higher education system should set up relevant majors.	3.93/1.109	4.45/1.146
Parent organization should have more impact in the society.	2.61/1.297	3.33/1.382
Schools and medical systems should provide more information to parents/teachers.	3.13/1.353	3.15/1.392
There is a need to have more relevant books and assistive technology.	1.79/.989	2.07/1.389
There is a need to have high quality training centers to provide effective instruction and training.	4.31/1.405	–
Salary for teachers should be increased.	–	2.72/1.389

Note. The caregivers and teachers were asked to rank possible solutions from “1” to “6” to indicate the importance of each solution. The “1” stands for the most important solution and the “5” stands for the least important solution.

Reported Teacher Stress

Some of the questions were designed to address teachers’ current living environment, working environment, convenience of daily living, salary, health status, and work-related stress. Regarding living environment, 6.2% of teachers

were “very satisfied,” 25.8% were “satisfied,” 41.2% were “neutral,” 19.6% were “unsatisfied,” and 7.2% were “very unsatisfied.” Regarding working environment, 2.1% were “very satisfied,” 34% were “satisfied,” 44.3% were “neutral,” and 18.3% were “unsatisfied” or “very unsatisfied.”

Table 5

Weights of Major Concerns in Caregivers of Children with ASD

<u>Items</u>	<u>Caregivers</u> (Mean/SD)
Future and career of the child	5.89/1.040
Personal career is impacted by the child’s disability.	3.14/1.308
Not sure whether the ASD can be cured.	6.03/1.185
Financial situation is not good enough to support relevant educational expenses.	3.81/1.444
Family relations are deteriorating due to child’s disability.	2.14/1.186
The child cannot take care of parents in the future and we are wondering about having a second child.	2.64/1.581
If parents passed away, we are unsure what to do with the child.	5.24/1.528

Note. The caregivers and teachers were asked to rank possible solutions from “1” to “7” to indicate the importance of each factor. The “1” stands for the most important solution and the “7” stands for the least important solution.

Regarding salary and benefits, only 3.1% of the teachers were “satisfied,” 46.4% were “neutral,” and 50.5% were either “unsatisfied” or “very unsatisfied.” Regarding health status, 42.9% of the teachers were either “very satisfied” or “satisfied,” 38.8% were “neutral,” and 18.3% were “unsatisfied” or “very unsatisfied.” Regarding work-related stress, 62.9% of the teachers reported “very significant” or “significant” working stress, 38.8% reported “average” stress, and only 9.3% reported “little stress.” When asked about the 5- to 10-year plan, only 39.8% of the teachers indicated an intention to stay in their current jobs, 9.7% wanted to obtain advanced degrees, 5.4% wanted to transfer to other professions, 5.4% wanted to establish their own ASD training facilities, 2.2% wanted to transfer to other special education schools, and 37.6% had no future plans.

Correlations among teachers’ education, salary, and measured stress-related variables are shown in Table 6. Education levels were positively correlated with salary level and a higher level of dissatisfaction with home environment, employment salary, and benefits. A higher level of salary was positively correlated with a higher level of dissatisfaction with health status and work environment. A higher level of dissatisfaction with home environment was positively correlated with a high level of dissatisfaction with salary, benefits, health status, and work environment. Higher levels of dissatisfaction with salary and benefits were positively correlated with higher levels of dissatisfaction with work stress and higher levels of dissatisfaction with the work environment.

Discussion

Epidemiological Findings and Demographic Data Unique to Chinese Culture

Analysis of the demographic data collected in this study concurred with empirical findings regarding ASD in the U.S. and other Western countries, but also revealed phenomena that are unique to Chinese society. Random selection of the 10 schools and facilities serving children with ASD in China supported the general notion that ASD occurs more frequently in males (89% in this study), with approximately three or four males for every one female with ASD (Fombonne, 1999; Volkmar, Szatmari, & Sparrow, 1993). Autism symptom onset occurs within the first year of life based on parents’ reports (Lord, 1995), and parents express concerns to their pediatricians by the time their child is 18 months of age (Siefel, Pilner, Eschler, & Elliot, 1988). However, a formal diagnosis of ASD is often not given until 4 years of age (Siegel et al., 1988). In the current study, the mean age of diagnosis was 3 years, indicating that pediatricians in China were able to provide an accurate clinical diagnosis of ASD at an age comparable to their Western counterparts. The finding that 52.3% of the ASD children surveyed were non-verbal confirms the historical report that approximately 50% of individuals with ASD do not use words to communicate (Rutter, 1978). However, with the availability of early identification and intervention, this estimate is believed to be decreasing (Klinger, Dawson, & Renner, 2002). Genetic heredity has been well documented in families with ASD. The prevalence rate of 5% in siblings in the current study is consistent with a prior report of a prevalence rate among siblings of 6% (Szatmari, 1999); this is approximately 15 to 30 times higher than the prevalence of ASD in the general population (Klinger et al., 2002). Although this is not an epidemiological study on ASD, relevant information regarding the onset, sex differences, language, communication abilities, and prevalence reported by caregivers appeared to support the notion that ASD can be considered a universal disorder (Klinger et al., 2002).

The One Child Policy has been imposed by the Chinese central government since 1979, and local government

Table 6

Correlations of Teacher Education/Salary and Measured Stress-related Variables

	1	2	3	4	5	6	7
1. Education	–	.256*	.208*	.226*	-.008	.100	.077
2. Salary	–	–	.131	-.149	.281*	.083	.386**
3. S-Home environment	–	–	–	.467*	.043*	.123	.204*
4. S-Salary/benefits	–	–	–	–	-.036	.207*	.236*
5. S-Health	–	–	–	–	–	.011	.107
6. Stress from work	–	–	–	–	–	–	.156
7. S-Work environment	–	–	–	–	–	–	–

Note. The weights of satisfaction were defined as 1 for “very satisfied” to 5 for “very unsatisfied.” S stands for the degree of satisfaction with each variable.

considers it a “political task” to demonstrate their political compliance. Parents who have more than one child without legal permission might be subjected to large fines or be denied bonuses at their workplaces. Although Chinese parents are allowed by the law to have a second child if their first child has a documented disability, the Chinese public has been used to a “three-person family” structure for about three decades. Parents of children with ASD may choose not to have a second child; in the current study, only one fifth of the families had a second child. In addition to the constraints of the One Child Policy, it remains unclear whether the choice of not having a second child is impacted by the fear of having a second child with ASD.

The finding that approximately half of the participants with ASD were living in an extended family reveals the difference in family structure between China and its Western counterparts. The groundwork of American social structure is individual, whereas the groundwork of Chinese society is familial (Guo, Luo, & Zhou, 2007), which is common in collectivistic culture. There is a strong bond between Chinese grandparents, parents, children, and other family members. Even for children who live in nuclear families, their grandparents may provide childcare support during weekends and workdays. Grandparents’ extensive involvement in the daily living of their grandchildren is a common phenomenon in Chinese culture.

Financial Impact

Stress triggered by concerns regarding family finances has been documented (Jarbrink et al., 2003). A cost analysis revealed that the cost of education-related activities in private schools in China was about three times as much as the cost in public schools. In public schools in China, tuition is waived, but parents have to pay for textbooks, supplies, field trips, and lunch fees. Although this study did not involve a control group of children without disabilities, we can postulate that sending

a child with ASD to a private school in China costs three times that of sending a child (without or with disabilities) to public school, concurring with Dobson and Middleton’s (1998) estimation. Given that the majority of the children with ASD surveyed were in private schools, the financial burden may have a universal impact on many Chinese families of children with ASD.

In examining the nature of schools and training facilities in China, the teachers surveyed were all employed by private employers. This observation was not due to a sampling error. Currently, the Chinese government is primarily responsible for three types of special schools serving children with intellectual disabilities, deafness or hearing impairment, and blindness or visual impairment. Public special schools specifically designed for children with ASD are not common in China. As a result, children with ASD are often sent to private schools or facilities for schooling. With a reported monthly salary at or below 1,500 RMB (approximately 221 USD), special education teachers hired by private schools/facilities are underpaid, in comparison to a base rate of 2,000 to 3,000 RMB (approximately 291 to 441 USD) per month for teachers hired by public schools (Radio Beijing Corporation, 2009). This observation is consistent with previous reports of relatively low salaries for special education teachers in China (Ding et al., 2006). In addition, the majority of the teachers surveyed did not have health insurance because they were in private schools or facilities. Low monetary rewards and salaries coupled with poor health coverage may deteriorate teachers’ motivation to continue working with this population. It is not surprising that the teacher participants ranked increase in salary as one of the most important solutions to improve autism education.

Although the Hukou system (residence permit system) in China is a novel concept in many Western countries, it has existed in China since Xia dynasty (1600 B.C.) with an essential purpose of centralized control of taxation, conscription, and social stability. To some degree, the

residency permit system limits mass migration from the farmland to the cities to ensure structural stability in the larger society. If a person does not have legal residency in a specific area, that person is subjected to a higher cost of living for sending a child to a local public school, obtaining a driver's license, or using the public resources in that area. Most teachers employed by the private schools in this study lived in a city where they did not hold legal residency, which may have contributed to a higher cost of living.

In terms of minor monetary rewards, Chinese teachers hired by the public schools often receive tokens of appreciation from the Ministry of Education of the local government, such as coupons for food and supplies. However, the teachers employed by the private schools in this study did not receive such tokens of appreciation from the government. It appears that both overt (i.e., salary) and covert (i.e., benefit, residency, token of appreciation) financial factors presented a complex picture of these teachers' circumstances. These teachers earned lower salaries with minimal or no health insurance, and the cost of living was higher because most did not have residency permits in the cities where they lived. Additionally, they did not receive minor rewards from local government as tokens of appreciation. According to Maslow, low-level needs such as physiological and safety needs must be satisfied before high-level needs such as self-fulfillment are pursued (Wilson, 1972).

Caregiver-Teacher Communication

Caregivers with different levels of educational background and incomes did not differ in their effort to communicate with teachers. However, caregivers with lower frequencies of caregiver-teacher communication reported higher levels of dissatisfaction. It remains unclear whether dissatisfaction contributed to less effort to communicate, less communication contributed to a higher level of dissatisfaction, or there was a bidirectional relation (e.g., communication contributed to higher satisfaction, which reinforced more communication, and vice versa). The majority of caregivers and teachers reported a preference for face-to-face communication.

Limited Professional Training and Support

Limited professional training and social support for children with ASD appear to be considerable barriers for caregivers. Caregivers ranked "more relevant books and assistive technology" as the top solution for the improvement of autism education, indicating an urgent need for professional knowledge and skills relevant to ASD. The low percentage of caregivers looking for community resources reflects the reality of fragile community support in current Chinese society. Because there are very few parent associations for children with disabilities in China (Ding et al., 2006), these caregivers turned to inter-parent support and to their own resources (e.g., using the Internet).

In terms of teacher professional training, 16.3% of teachers had a special education background and only one-tenth had a college or postgraduate degree, indicating that many Chinese teachers working with children with ASD may not be well prepared to teach these children if no in-service training is provided. Fortunately, a majority of the teachers in this study reported receiving in-service training after they were hired. However, the quality of in-service training may vary from site to site. According to Cherniss's (1995) conceptualization of burnout, teachers of children with ASD may be at risk for burnout unless they acquire appropriate teaching tools.

The autism community and relevant support networks in China are not as well developed as those in the Western countries. The report that a low percentage of children received services from professionals other than teachers coincides with the research by Ding and colleagues, suggesting that special educators in China are often the sole and primary providers for individuals with disabilities (Ding et al., 2008). As a result, teachers may have to assume more responsibilities in their daily teaching. Extra responsibilities added to limited professional training can be burdensome.

Parenting Stress and Teacher Stress

Raising a typically developing child can be stressful (Crnic & Greenberg, 1990); parents of children with disabilities are at greater risk of experiencing elevated levels of stress (Baker-Ericzen, Brookman-Frazee, & Stahmer, 2005). During the period prior to an adequate diagnosis, parents may begin to notice cognitive and behavioral characteristics in their child that are unique to ASD. This period averaged 3 years in the current study compared to a previous report of 4 years based on a national survey in the UK (Howlin & Moore, 1997). A child's receiving a diagnosis of ASD leads to mixed emotions in parents (Mansell & Morris, 2004); the process from diagnosis to acceptance averaged 1.32 years in the current study. It was surprising that half of the families still had family members who had not progressed to the acceptance and adaptation stage. Caregiver reports revealed that the deteriorated family relationship was the most severe source of stress related to ASD. In Chinese culture, having a child with a developmental disability may impose particular stress on mothers, reflect negatively on their families, and affect their status and relationships within the extended family and larger social circles (Ow & Katz, 1999). This finding is supported by previous findings regarding relationship-focused coping mechanism to be more suitable for an understanding of caregiver perceptions within collectivistic cultures (Mak & Ho, 2007).

It is not difficult to understand why Chinese family relationships are severely deteriorated by a diagnosis of ASD, given the fact that most Chinese families have only one child. China is an ancient country that favors boys as a legacy of Confucian culture (e.g., men were superior to women). This phenomenon is also seen in India, Taiwan, and Pakistan, and

even in the U.S. in communities composed of immigrants from these countries (Almond & Edlund, 2000). Unfortunately, ASD is diagnosed more frequently in males, which can result in considerable stress for a Chinese family with one male child who has ASD. In this study, caregivers ranked “wondering about having a second child” as one of the top two concerns for the family. Having a second child can give parents another chance to have a healthy child; however, genetic factors play a role in the etiology of ASD (Klinger et al., 2002) and parents may have concern about having another child with ASD.

Teacher stress in this study was related to monthly salaries, benefits, health insurance, and work-related stressors. The teachers surveyed reported income levels that were lower than general education teachers employed in public schools, and their satisfaction with salary and benefits was low. This observation is consistent with previous research with Chinese teachers of children with intellectual disabilities (Ding et al., 2006). A majority of the teachers in the current study also reported significant work-related stress and indicated the need for “more relevant books and assistive technology.” According to Cherniss (1995), appropriate tools and knowledge should be provided to these teachers to help them remain compassionate toward their clients, feel rewarded, and avoid burnout. In the absence of necessary knowledge and appropriate tools, it is not surprising that less than two-fifths of the teachers were committed to staying in their current positions. Teachers with higher educational levels had higher expectations regarding their salaries, benefits, and home environments, which may have contributed to a higher level of dissatisfaction with these variables. A higher level of dissatisfaction with salaries and benefits in turn exacerbates work stress and dissatisfaction within the work environment. Such correlational findings appear to indicate that teachers with higher levels of education may be more likely to resign from current positions.

Limitations and Conclusions

The present study had a number of limitations. First, participants were limited to 108 caregivers and 98 teachers in urban China. It is unknown whether the characteristics of caregivers and special education teachers in rural settings would be similar. Second, all special education teachers surveyed were employed by private schools or training facilities and their perceptions might be different from teachers employed in public school settings. Third, the information regarding parenting stress and teacher stress was based solely on participant responses to the questionnaires. Ideally, stress is better assessed by using a variety of methods (e.g., both qualitative and quantitative) to provide a more comprehensive view of an individual’s stress levels.

In short, this study complements the limited literature on Chinese children with ASD. Five aspects of the findings summarize this study. First, the epidemiological data on prevalence, gender differences, genetic factors, prevalence,

and onset of symptoms supported the notion that ASD is a universal disorder. Second, extended family, which is defined as one child living with parents and grandparents, is still the most common family structure in China. The dependence on support from extended family is unique to the collectivistic culture. The majority of the families surveyed had only one child. Future research should explore how and to what extent the One Child Policy has impacted Chinese families of children with disabilities. Third, financial factors have an impact not only on Chinese families but also on teachers, indicating that the caregivers and teachers of children with ASD were still struggling with basic living needs. Fourth, because of limited professional training and social support in the Chinese community, caregivers turned to inter-parent support and self-learning as their coping mechanisms. For teachers with limited professional training, lack of support from other professionals makes teachers’ work even more challenging. It highlights the need for family interventions and in-service trainings to enhance both caregivers’ and teachers’ skills. Finally, the predominant source of stress in the Chinese families in this study was reported to be the deterioration of family relationships, whereas low salary and poor benefits seemed to be the main source of stress diminishing teachers’ commitment to special education. The findings highlight the importance of developing a relationship-focused coping mechanism for Chinese families. In addition, teacher-directed services should consider teachers’ basic and necessary financial needs.

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Response to Intervention: Implications for the Proficiency of Early Childhood Special Educators

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Abstract

Collaboration seems to be an almost inherent theme in most current trends and theories shaping early childhood special education reform; so much so, that we possibly reference these theories only in terms of their collaborative nature, without fully understanding them. Response to Intervention is currently getting a great deal of attention, not only due to its inclusive nature regarding other promising educational concepts (such as differentiated instruction), but because included in the RTI framework are implications regarding the current system of testing for special education eligibility and the categorization of students receiving special education services. This paper presents a review of where the field may be heading with future initiatives regarding early childhood special education and how it relates to implications for the early childhood special needs teacher.

Introduction

Collaboration seems to be an almost inherent theme in most current trends and theories shaping special education reform; so much so, that we possibly reference these theories only in terms of their collaborative nature, without fully understanding them. Most of these trends address educational settings or modes of delivering instruction to children with exceptionalities: Inclusion, Mainstreaming, Co-teaching, and more recently, Universal Design for Learning (UDL) and Response to Intervention (RTI). All these are meant to indicate a better and more collaborative means of providing services to students with exceptional learning needs.

Of these, RTI is currently getting a great deal of attention, not only due to its inclusive nature regarding other promising educational concepts (such as differentiated instruction), but because included in the RTI framework are implications regarding the current system of testing for special education eligibility and the categorization of students receiving special education services. One of the authors (Mack, 1996; Mack, 2001) reported the need for teachers to systematically connect their instruction to benchmarks in determination of “ameliorization instruction.” In an attempt to gain a greater understanding of the direction that we might be

heading with future initiatives regarding special education and how it relates to collaboration, we have taken a closer look at RTI.

History of RTI

The Discrepancy Model (DM) has been used as a procedure for identifying children with a specific learning disability by examining test score discrepancies between a child’s IQ and their educational achievement. RTI was developed starting in the late 1970s by numerous researchers seeking a method of identifying learning disabilities that avoids the problems of the DM (Mack, 1999). RTI allows for early and intensive interventions in the general education setting, unlike the DM, based on a student’s learning characteristics before any referral to special education. The benefit of RTI, according to the Council for Exceptional Children (2008) is that children do not have to “wait to fail” before they receive help.

In the United States of America, RTI was recognized in the 2004 reauthorization of the federal government’s Individuals with Disabilities Education Improvement Act (2004) as one option that school districts can use to identify students with specific learning disabilities. The federal law states that when determining if a child has a specific learning disability,

schools are not required to use the DM and have the option of using procedures that determine if the child responds to scientific, research-based interventions as part of the evaluation procedure. The revision in the federal guidelines extended the option of using RTI instead of, or in conjunction with, the DM in qualifying children for special needs services.

What is the RTI Model?

RTI is a relatively new approach to identifying students who are at-risk for achieving benchmark goals in various areas of achievement. Basically, it is a process for monitoring data to establish the application of empirically tested instruction. RTI may be more broadly defined as an approach that uses students' response to high-quality, research-based, instruction to guide educational decisions, including decisions about the efficacy of instruction and interventions, eligibility for special programs, design for individual education programs, etc.

RTI most often is identified as a three-tiered approach recommended as a way to incorporate educational problem-solving school wide. It emphasizes the collaborative integration of general and special education instructional efforts. RTI should be applied to decisions in general, remedial and special education, creating a well-integrated system of instruction/intervention guided by child outcome data (Jimerson, Burns, & VanDerHeyden, 2007). The three tiers may be described as follows: screening and group interventions (benchmark level), targeted interventions, and intensive interventions and comprehensive evaluation.

Tier 1: Screening and Group Interventions (Benchmark Level).

Students who are "at-risk" are identified using universal screenings and/or results on state or district-wide tests and could include weekly progress monitoring of all students for a brief period. Identified students receive supplemental instruction, or interventions, generally delivered in small groups during the student's school day in the general classroom. The length of time for this step can vary, but it should not exceed eight weeks. During that time, student progress is closely monitored using a validated screening system. Students meeting the expected level of performance are given the core instructional program and need no further assessment or intervention. Approximately 80-to-85% of the students would be expected to meet benchmark levels of intervention without the need for further intervention (Simmons, Kame'enui, & Good, 2002; Sugai & Horner, 1999). At the end of this period, students showing significant progress are returned to the general classroom program. Students not showing adequate progress are moved on to Tier 2.

Tier 2: Targeted Interventions

Students not making adequate progress in the general classroom in Tier 1 are provided with more intensive services and individual interventions. The services are provided in addition to instruction in the general curriculum. These interventions are provided in small group settings. In the early grades (K-3) interventions are usually in the areas of reading and math. A longer period of time may be required for this tier, but it should generally not exceed a grading period. Approximately 15-to-20% of the students in a school would be expected to need targeted intervention to meet expectations (Simmons et al., 2002; Sugai & Horner, 1999). Students who continue to show little progress at this level of intervention are then considered for more intensive interventions as part of Tier 3.

Tier 3: Intensive Interventions and Comprehensive Evaluation

Students receive individualized, intensive interventions that target the student's skill deficits. Approximately 5-to-10% of the students in a school would be expected to need intensive intervention (Simmons et al., 2002; Sugai & Horner, 1999). Students who do not respond to these targeted interventions are then considered for special education.

Instruction and Outcomes

In Granner, Faggella-Luby, and Fritschmann's (2005) overview of RTI, they describe eight core features: high quality classroom instruction, research-based instruction, classroom performance measures, universal screening, continuous progress monitoring, research-based interventions, progress monitoring during interventions, and fidelity measures. In addition to these features, they go on to describe five common attributes that one might find in an RTI model, depending on the type of RTI model being implemented: multiple tiers that transition from instruction for all to increasingly intense interventions; implementation of differentiated curriculum; instruction delivered by staff other than the classroom teacher; varied duration, time, and frequency of interventions; and categorical or non-categorical placement decisions (Granner et al., 2005).

The Michigan Association of Administrators of Special Education manual, *Response to Intervention Enhancing the Learning of All Children* (2007), presents eight core principles that define the RTI model in the lay language of educational practitioners. They are (a) we can effectively teach all students, (b) intervene early by identifying at-risk students through universal screening, (c) a multi-tier model for service delivery provides a systematic approach to support student learning, (d) use a problem-solving model to make decisions within a multi-tier model, (e) use scientific, research-based validated interventions/instruction, (f) monitor student progress to inform instruction, (g) use data to make decisions, and (h) use assessment for three different purposes.

In a more simplistic explanation, Fuchs and Fuchs (2006) outline the basic construct of RTI as involving a series of tiers, each intended to provide a varying degree of diagnostic measure and intervention. As implied by these broad range definitions of RTI, models vary in intended purpose and design. In terms of intended purpose, there are those that view RTI as a diagnostic tool and those that view RTI as a method of providing a continuum of educational interventions. Design variation includes those that address the collaborative aspect of RTI from a standard protocol approach and those that address it using a problem solving model (PSM).

Two schools of thought guide the views on RTI. Some view RTI as a diagnostic tool that might potentially replace the DM used to determine eligibility for individuals with specific learning disabilities. This theory that emerged as the DM of identification underwent more scrutiny, RTI gained recognition as a more needs specific means of identifying students who remained unresponsive to intervention. Others view RTI as a means of providing a continuum of supports for students requiring more specialized instruction and instructional techniques. Along that continuum, the process might also include RTI as a pre-referral tool for identifying those in need of more formal testing. Both models of RTI include design variation related to whether or not they adhere to a standard protocol approach or a problem solving approach.

Not only are there differences in the intended purpose or outcome of RTI, there are differences as to the method of implementing RTI as well. Some models use a standard protocol approach, while others use a PSM. The PSM can be broken down further into subsets of those that use a behavioral approach to problem solving and those that use a collaborative approach to problem solving.

The standard protocol approach (SPA) to RTI involves using a fixed process and research-based intervention for all students. This method of delivering intervention includes increased instructional time and reduced group size (Granner et al., 2005). As noted by Fuchs, Mock, Morgan, and Young (2003), the SPA approach to RTI is endorsed by reading researchers, and professional organizations, as it outlines an empirically-based, systemic process. The end result of the SPA to RTI is that students who respond to intervention are considered able to receive instruction outside of the special education program, and those who do not respond are moved to a more intensive tier of intervention. More intensive tiers include a second or third tier depending on the model, with the last tier indicating the need for testing for special education for those that are still not responsive.

The PSM is split into two groups. These two approaches to RTI include a behavioral approach to problem solving and a collaborative approach to problem solving (Graner et al., 2005). The behavioral problem solving model is derived from the standpoint that a given intervention will not necessarily work for all students of a particular group. Fuchs et al. (2003) go on to explain that the process involved in this model includes steps of problem identification and analysis, plan

development, plan implementation, and problem evaluation. These steps are implemented throughout the stages of the RTI model. The collaborative problem solving approach is described as a hybrid variant of the behavioral approach, and includes a collaborative consultation component that incorporates specialists in the problem solving stages (Fuchs et al., 2003).

Illustrative examples of SPA and PSM models can be found in the work of Fuchs et al. (2003) and Graner et al. (2005). To look at these examples we must first remember the different purposes of RTI as well as the different approaches. We can then divide the examples into the following groups: standard protocol approach, behavioral problem solving as decision making for eligibility, and collaborative problem solving as pre-referral intervention.

Standard Protocol Approach to RTI

A well-noted example of the use of the SPA to RTI as a process of remediation for struggling readers is demonstrated in the work of Vellutino, Scanlon, Sipay, Small, Chen, Pratt, & Denckla (1996). During the second semester of their first grade year, students identified by Vellutino and his colleagues, received one-on-one tutoring. Those first grade students who did not make the projected gains received another ten weeks of tutoring in the fall of second grade. Again the students were re-tested, and those who remained unresponsive were described as “difficult to remediate.” Another more recent study demonstrating SPA was conducted by McMaster, Fuchs, Fuchs, and Compton (2005), who used variations of the PALS reading program as intervention for those individuals identified as at risk when using a dual discrepancy model of identification. Although this study did not yield statistically significant results regarding the chosen standard protocol (Peer-Assisted Learning Strategies), it does serve as a good example of implementing the process of a SPA approach to RTI.

Behavioral Problem Solving Approach to RTI as Decision Making for Eligibility

Those offering an overview of RTI commonly cite two examples of a PSM of RTI for decision making; the Minneapolis Experience (Marston, Muyskens, Lau, & Canter, 2003), and research conducted at the Heartland (Iowa) Educational Agency (Fuchs et al., 2003; Fuchs & Fuchs, 2006; Graner et al., 2005). The Minneapolis Experience utilizes a “four step sequence of identifying and supporting students with academic difficulties” (Marston et al., 2003). These steps repeat through the three stages of intervention. Using data collected during these three stages along with additional information and observations, a student may be identified as a “Student Needing Alternative Programming” (Marston et al., 2003).

Heartland’s model of implementing RTI differs from Minneapolis in that Heartland has a seven step sequence for

their problem-solving process which is repeated during four levels (instead of stages) of intervention (Fuchs et al., 2003). It is a student's performance compared to other students in their same classroom that determines a student's eligibility for special education (Fuchs & Fuchs, 2006).

Collaborative Problem Solving Approach to RTI as Pre-referral Intervention

Pennsylvania's Instructional Support Teams (ISTs) and Ohio's Intervention Based Assessment (IBA) are based on processes similar to those in Minneapolis and Heartland. Pennsylvania's ISTs include a support teacher in addition to the principal, student's teacher, and other teachers and specialists as needed (Graner et al., 2005). The support teacher is responsible for providing the supportive activities, monitoring progress, and collecting data.

The primary difference between the behavioral PSM and the collaborative approach of Ohio's IBA is the use of an eight component model for problem solving and the introduction of a multidisciplinary team as part of the process (Fuchs et al., 2003; Graner et al., 2005). The multidisciplinary team includes a school psychologist and special education teacher in addition to the classroom teacher and principal. In both of these models, a student who is still unresponsive to intervention after having moved through subsequent stages of intervention would be referred for testing to consider the possibility of special education eligibility.

Criticism regarding the different models allows one to consider the relative strengths and weaknesses of each. Fuchs et al. (2003) point out that there is a lack of research supporting problem-solving models in terms of accomplishing the goals implied by RTI; namely, reducing the number of students identified for special education services and validating the need to replace the discrepancy model used for identifying students as specific learning disabled. Other criticisms include the use of interventions with no scientific validity and an absence of data reporting on the fidelity of such interventions. Although supported by research-based intervention, the SPA model of RTI has its flaws too.

Using the work of Vellutino et al. (1996) Fuchs et al. (2003) question the effects of the one-on-one nature of the chosen intervention as the more significant variable related to success. In addition to this, one might question whether one standard treatment is appropriate for all children and the ability of the standard intervention to produce results after the student has reached the expected level and returns to the classroom without additional support (Fuchs et al., 2003). One must also consider the lack of research regarding an SPA approach to RTI in areas other than reading.

In summarizing their overview of SPA and PSM models of RTI, Fuchs and Fuchs (2006) state, "As best we know, however, the comparative fidelity of implementation (and effectiveness) of the two approaches has not been explored within the same experimental design. Such exploration

represents an important and promising area of research" (p. 96).

Two examples of an attempt to do so may be found in the research of VanDerHeyden and Jimerson (2005), and Barnett, Daly, Jones, and Lentz (2004). Before examining these it helps to look at VanderHeyden's (2005) work regarding early childhood intervention and curriculum based assessment (CBA) versus curriculum based measurement (CBM), and Noell and Witt's (1999) work regarding consultation, collaboration, and intervention implementation.

To distinguish between CBA and CBM, VanDerHeyden (2005) directs one to think about the difference between short term goals and overall area of need, respectively. A close examination reveals that CBA is used to analyze a subset of skills. VanDerHeyden offers the example of a child's learning to drink from a cup. Sub-skills might include a child's ability to physically manage the task (grasp, hand-eye coordination, etc.), or they might include other skill-related behavioral components (does not like fluid being offered, is not thirsty, etc.). To evaluate, using CBM, whether or not a child has mastered the skill, one must first use CBA to analyze the subsets leading to that skill. The challenge, according to VanDerHeyden (2005), lies in "identifying adequate indicators of progress that are linked to important functional outcomes." An example, in an academic context, of a CBM that attempts to do this can be seen in the Dynamic Indicators of Basic Early Literacy Skills (DIBELS) assessment used to identify children at risk for reading failure. VanderHeyden's (2005) work suggests there is a need to use task analysis when determining student interventions, accomplished through the use of CBA. In turn, CBA may be the more relevant RTI tool; whereas, most RTI research cite CBM as the authoritative measure.

VanDerHeyden along with Jimerson (2005) report their findings regarding the implementation of an RTI model that utilizes components of the PSM as well as the standard-based protocol SPA. The model involves three stages based on a problem-solving model of assessment called Screening to Enhance Equitable Placement (STEEP). During the first stage CBM is used to conduct a school wide universal screening, and CBA were administered to students identified as a result of the screening. The data is then analyzed and problems are categorized as class wide or specific to an individual. During the second stage, a consultant monitors progress and determines whether other intervention strategies or assessments should be used. It is during the third stage that a SPA intervention is implemented, and non-responders during this stage are referred for a full eligibility evaluation (VanDerHeyden & Jimerson, 2005).

Flaws in the PSM of RTI are largely based on the lack of empirical research supporting the efficacy of collaborative consultation. Noell and Witt (1999) discuss the challenges involved in such an effort and point to several obstacles when trying to measure consultation and collaboration. Among these, is the difficulty identifying appropriate independent and dependent variables. Measures that rely on participant reports

and ratings can only summarize the perceptions of those polled. Measures of progress as evidence of successful consultation do not account for variations regarding implementation.

These variations exist in the absence of a finite measure to determine variables such as the extent to which administrators support consultation, the extent to which participants are accountable for implementation, and the availability of resources (Noell & Witt, 1999). Although a need exists for an analysis of consultation using scientifically-based methods of investigation, Noell and Witt (1999) conclude that research developed using a process guided by experimental design is promising.

Barnett et al. (2004) outline a PSM of RTI that takes into account these concerns regarding collaborative consultation. Rather than defining stages or phases of intervention, the model is based on a process of increasing and decreasing the intensity of interventions. In this model, interventions are case specific, and rely on data measures of child outcome variables, and intensity of intervention variables. Intensity variables may include qualitative characteristics such as routines, location, resources, or changes (such as the amount of time). This single-case design for RTI outlines a standard-based method of applying a problem solving model of RTI.

Classroom Teacher Reflections on RTI

Using an embedded question in a final examination for two graduate classes at Grand Valley State University, nearly 90 practicing teachers were asked to respond to the benefits and limitations of the RTI process (Mack, Smith, & Staight, 2009). Collapsed summaries of responses are given in Figure 1.

The same teachers were requested to offer recommendations for teachers who were new to RTI. They offered the following recommendations:

1. Observe a school or classroom that has incorporated RTI in the provision of early childhood services.
2. Become aware of the research that supports the effectiveness of the interventions and instructional programs being used.
3. Be sure that communication is open among all people involved; including other teachers, administration, special needs staff, and parents.
4. For RTI to be successful, teachers need to be well prepared and aware of the school district's RTI philosophy.
5. Keep accurate and up to date records of test results, interventions used, parent communication, and progress made on each student.
6. Obtain a mentor in your school district who is currently involved in RTI.
7. RTI, as a single process, is not sufficient to identify a specific learning disability.
8. Request training to make you fully aware of research-based interventions.

9. What is done for one child may not work for another child, so don't give up.
10. Keep parents involved and work with them on interventions to be attempted at home that may reinforce the interventions that are happening at the school.
11. Select instructional or behavioral management strategies that match the individual needs of each student.
12. Use professional teams to problem-solve and ask for help when needed.
13. Collaborate with other teachers in your grade level to identify appropriate types of interventions.
14. Learn to differentiate your instruction and maintain documentation that the intervention strategies you are implementing are in fact helping the student.
15. Respond to skill gaps early in the process so that there is more of a chance of preventing failure rather than fixing it.

Summary

In essence, arguments surrounding the differences in RTI models are based on the processes and methods used to identify students who are at risk, to determine which type of intervention is most appropriate, and to measure fidelity of implementation. For RTI to be effective in the early grades, RTI must be implemented as a multi-component system that requires general education and special education teachers to work together to collect and analyze student data, make data-based decisions, and apply appropriate instructional interventions based on individual student needs. The 2004 reauthorization of IDEA provides the option of using research-based interventions when determining the eligibility of a student with a specific learning disability. If for no other reason, it will take collaborative consultation to define "research-based interventions."

RTI appears to offer more relevant help for students at risk for learning disabilities and it provides critical information about the instructional needs of the student, which can be used to create effective educational interventions. An overview of RTI, as documented by teacher comments, will clearly demonstrate that this will not be an easy day's work. Schools must guarantee that teachers are highly trained to adjust and supplement the curriculum. According to Grant (2008), success of the RTI model is contingent on the effective use of progress data and awareness of those students who are not making progress.

The current trend in the United States of America is to respond to the needs of struggling and at-risk early childhood learners through the multi-tiered response to intervention models, and this implementation appears to be an eventual certainty in the country (Hoover, Baca, Wexler-Love, & Saenz, 2008). However, several questions still remain unanswered and in need of additional research. First, should the discrepancy model for identifying struggling learners be totally discarded? Second, where is the consistency in procedures to maintain the implementation fidelity on a state

RTI Benefits	RTI Limitations
Reduces the time a student waits before receiving additional instructional assistance, including special education if needed.	Requires more resources to be effective and teachers who have been adequately trained to proctor assessment, monitor progress, and apply best practice interventions.
Provides early intervention for students who may not be referred for special testing the early education classroom setting.	Large class enrollments and school budgets may make RTI an unrealistic goal.
Provides additional assistance to learners before the exhibition of chronic failure.	Challenge of differentiating classroom instruction in a class with a high number of at-risk learners.
Use of the on-going collection of data and application of best practice.	Requires a coordinator who is able to efficiently define the blending of general education and special education staff tasks.
Focus away from the identification of deficits and moves toward examining student outcomes.	Special needs students identified under the DM may not qualify for the on-going delivery of special needs services.
Promotes the general education teacher as a significant member of the intervention team.	Since the intervention is individualized, RTI may require one-on-one instruction, restricting the overall number of students serviced.
Keeps students with their peers and does not exclude them from regular classroom activities.	Many educators may assume that because a student is in Level 3 of RTI, they are in need of special education services.
Students do not have to show a significant deficit to obtain assistance—students who are achieving one grade level below their peers obtain assistance.	RTI creates another classroom transition for students who already have difficulty with transitions.
Use of progress monitoring assures that students are assessed regularly to make sure that they are meeting individual goals.	Little is known about the effectiveness of RTI outside of language arts and reading.
Differentiates between inconsistent instruction and special needs, as contributing to the child's learning delays.	RTI tends to be focused on the early elementary grades and little information and research is available beyond elementary school.
Useful in identifying students in the early grades who have a specific learning disability.	Since most RTI interventions occur in the general education classroom, fewer special education teachers may be required.
Reduces the overall number of students referred for special education services and increase the number of students who succeed within general education.	Since an RTI process identifies the lowest performing students within a group, students who are highly intelligent yet are not performing up to their potential will most likely not be identified for special education intervention.
Ensures that students receive appropriate instruction, particularly in reading, prior to placement in special education.	RTI alone is generally not sufficient to identify a learning disability.

Figure 1. Benefits and limitations of Response to Intervention

and national basis? Third, how has RTI efforts responded to the culturally and linguistically diverse student populations? Fourth, is RTI a one-size-fits-all procedure and what range of flexibility is required to best serve all students? Fifth, what is the effectiveness of RTI decision-making models in identifying struggling early learners and the reduction in the need for special education referrals and/or placements? There is much hope and optimism regarding the application of RTI in the early grades.

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Comparison of Quality of Life Perceptions of Caregivers of Individuals with Intellectual Disabilities in the United States and the Czech Republic

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Abstract

Caregivers of individuals with disabilities in the United States have been reported to experience additional hardships than families with typical children as they attempt to balance family and work (Parish, Rose, Grinstein-Weiss, Richman, & Andrews, 2008). In this study, 31 caregivers of individuals with intellectual disabilities from the United States and 225 from the Czech Republic completed a qualitative quality of life survey. Similarities in the two groups were found in reported gains and losses from caregiving responsibilities. Differences in perceived spirituality, personal sense of peace and serenity, life optimism, ability to rejoice in life, personal life perspective, health, financial changes, changes in the family social life, feelings of enrichment, family caregiving responsibilities, and attitudes about the future were also revealed. The implications for supporting families through governmental programs and individualized services are discussed.

A disability is a culturally and socially constructed phenomenon in which each society defines the parameters of what is considered “typical” (Linan-Thompson & Jean, 1997). Frequently parents do not perceive a disability the same way as professionals, especially when the diagnosis involves young children. The literature suggests that parents vary in their reactions, and that most parents go through a period of adjustment, with further adjustments as their child ages (Harden, 2005; Raver, 2009). Although parents and guardians expect to perform caregiving tasks during the upbringing of a child, when a child has intellectual impairments, roles and duties may change as caregivers face the possibility that a child may require long-term care beyond the typical child-rearing years (White & Hastings, 2004; Raina et al., 2005). Caregivers may experience stress and an array of other feelings as they adjust to the demands of caring for someone with special needs while trying to balance the needs of the entire family and work responsibilities (McDonald, Poertner, & Pierpoint, 1999; Plant & Sanders, 2007; Raina et al., 2004; Rosenzweig, Brennan, & Ogilvie, 2002). Providing care for an individual with a disability may drain financial resources and physical and emotional energy (Murphy, Christian, Caplin, &

Young, 2006). Research has shown that caregivers of children with disabilities report increased health and psychological problems when compared to parents of children without disabilities (Florian & Findler, 2001; Maes, Broekman, Dosen, & Nauts, 2003). Further, supplementary costs for medical procedures, therapies, and adaptations may increase financial pressures on caregivers, causing more tension (Parish, Rose, Grinstein-Weiss, Richman, & Andrews, 2008).

Despite this evidence, there are studies that have also shown that there may be positive outcomes from the process of caregiving for an individual with a disability (Grant & Whittell, 2000; Heiman, 2002). Clearly not all reactions to the birth of a child with a disability or the demands involved in caring for this child or adult may be characterized as negative (Turnbull, Turnbull, Erwin, & Soodak, 2006). Many parents and families make successful adjustments to their situation and report positive outcomes from caregiving such as increased family cohesion and a renewed appreciation for life (Raina et al., 2005; Raver, 2005). Over time, most parents and caregivers in the United States seem to adapt to their new realities, while remaining steadfast in their commitment to the family member with a disability (Emerson, 2003; Gallagher,

Fialka, Rhodes, & Arceneaux, 2003; Raver, Michalek, & Simpson, 2009). Policy makers in the United States have historically operated under the assumption that the level of social and educational services provided families will support family adaptation and reduce some of the long-term burden placed on caregivers (King, King, Rosenbaum, & Goffin, 1999). Although this practice has some social validity, few studies (e.g., Parish et al., 2008) have examined the impact of governmental support on the principal caregivers of children and adults with special needs.

Special Education in the Czech Republic

In January of 1993, the Czech Republic became an independent country, joining the North Atlantic Treaty Organization (NATO) in 1999 and the European Union in 2004. Since independence, the Czech Republic has attempted to create more equal opportunities for individuals with special needs and increase access to appropriate education (Special Needs Education in the Czech Republic, 2000). It has attempted to move away from a medical model of serving these individuals, although the majority of students with disabilities continue to be educated in special schools (Special Needs Education with the Educational System: Czech Republic, 2009). This practice thrives largely because special schools continue to be the first choice of parents or caregivers. Educational legislation and the basic principles of special education, health and social policies for individuals with disabilities are outlined in the Legislation for Individuals with Special Needs (1993) and the National Plan to Increase Opportunities for People with Disabilities (Anonymous, 1998), and are similar to those followed in the United States.

There is little research which compares the quality of life perceptions of caregivers in the United States and those in the Czech Republic. The present study examined two research questions; (a) are there differences in the perceptions of quality of life issues of caregivers of individuals with intellectual disabilities in the United States and the Czech Republic, and (b) does the level of governmental educational and social services and supports provided for individuals with intellectual impairments and their caregivers in the United State and in the Czech Republic impact these differences?

Method

Participants

Thirty-one caregivers of individuals with intellectual disabilities (e.g., mental retardation, autism) residing in the United States, and 255 caregivers of individuals with intellectual disabilities (labeled as having mental retardation) in the Czech Republic participated in the study. A caregiver was defined as any individual, at least 18 years of age, who assumed at least 50% daily caregiving responsibility of an individual with any degree of an intellectual disability. Characteristics of respondents from the United States and the

Czech Republic, and the individuals for whom they provided care, are summarized in Table 1. The majority of respondents in both countries were female (U.S. 74.2%; Czech Republic 81.3%) and were responsible for caring for a child (U.S. 77.4%; Czech Republic 67.56%). Most of the caregivers were married or in a partnership (U.S. 58.6%; Czech Republic 68.9%). The majority of respondents from the United States had a college education (61.3%) while the majority from the Czech Republic had completed secondary school (56.1%). Respondents from the United States cared for individuals they identified as having intellectual disabilities or mental retardation and/or autism. Those in the Czech Republic cared for individuals defined as mentally retarded which included some with additional health and physical disabilities. The majority of caregivers from the United States indicated that their family members' disability fell in the mild to moderate level of impairment (70.9%). The largest group receiving care in the Czech Republic was identified to be in the severe to profound level of impairment (72.9%). Finally, the majority of the American and Czech respondents had been employed for 16 or more years (U.S. 64.6%; Czech Republic 61.3%).

Procedure

To determine if there were differences in perceptions regarding quality of life issues and concerns between caregivers living in the United States and the Czech Republic, caregivers completed a paper survey by circling the response that most closely matched their opinion or perception. In the United States, the survey was distributed to two educational facilities and two family support groups in the eastern part of Virginia. Names were not placed on the surveys which contained instructions and a self-addressed, stamped envelope so completed surveys could be returned anonymously. In some cases surveys were placed in an envelope and sealed by the respondent and then handed to an associate of the research team. In the Czech Republic, surveys were distributed to five special and/or residential schools and two rehabilitation resource centers which were located throughout the country. Respondents completed the survey, sealed it in an envelope to keep it anonymous, and handed it to a representative of the research team. The survey took about 25 minutes to complete, and all participants completed it voluntarily. In the United States, 130 surveys were distributed, with a 23% return rate. In the Czech Republic, 250 surveys were distributed, with a 90% return rate. The surveys in the Czech Republic were distributed by administrators of special schools and rehabilitation centers which may have accounted for the higher rate of return in the Czech Republic.

Data Analysis and Instrument

All responses were calculated into percentages, including demographic information, and then compared by survey item and country. Responses to open-ended, write-in questions

Table 1

Characteristics of Caregivers in the United States and Czech Republic and the Family Member Who Received Care

Characteristic		Percent of Respondents	
		United States	Czech Republic
Gender	Female	74.2	81.3
	Male	22.6	18.7
Age	Up to 20 years	3.2	0.0
	Up to 30 years	22.6	4.9
	Up to 40 years	29.0	19.6
	Up to 50 years	25.8	17.3
	Up to 60 years	16.1	57.3
Living Status	Married/Partner	48.4	68.9
	Single	35.5	30.7
Time caring for family member with a disability	Up to 6 years	41.9	38.7
	Up to 10 years	16.1	22.7
	Up to 15 years	12.9	12.0
	Up to 20 years	19.4	12.9
	Longer than 30 years	3.2	10.5
	No answer	0.0	3.5
Residence	In a city	67.7	93.5
	In a small town	29.0	2.2
Education	Primary	3.2	10.2
	Secondary	12.9	56.1
	Vocational training	19.4	12.4
	University	61.3	17.8
Employment Length	0-15 years	32.3	36.5
	16 years and more	64.6	61.3
Currently Employed	Full time	64.5	17.8
	Part time	12.9	8.0
	No	19.4	71.5
Characteristics of Family Member Who Received Care			
Relationship to Caregiver	Child	67.7	67.6
	Sibling	16.1	1.3
	Relative	12.9	24.0
	Not related/Guardian	0.0	4.4
Age	Up to 6 years	32.3	5.3
	Up to 20 years	45.2	40.4
	Up to 40 years	9.7	11.6
	Up to 65 years	6.5	10.7
	Older than 65 years	3.2	32.0
Disability	Mental retardation	77.4	100.0
	Autism/MR	22.6	0.0
Severity of Disability	Mild-moderate	70.9	21.8
	Severe-profound	25.8	72.9
Facility Attending	School program & at home	80.7	92.4
	Year-round program	6.5	4.0
	Other	6.5	0.0
	No answer	0.0	3.6

were clustered into principal ideas, and then summarized by percentages. The survey was developed based on a literature review of caregivers' major quality of life indicators, life stressors, collaborations between American and Czech colleagues, and field interviews with other caregivers prior to the initiation of the study. Some items from The Family Quality of Life Scale (FQOLS) (Park et al., 2003) were adapted for the instrument. Excluding demographic questions, the survey had a total of 26 items and two open-ended questions, and was divided into two parts. Part I addressed demographic information including the following about the caregiver: gender; marital status; residence in city or small town; age; educational level; length of employment; length of time the respondent had been caring for the identified family member; and current employment status. Further, information about the individual being cared for was gathered: the disability; the severity of the disability; the age of the individual; the relationship of the individual to the respondent; and the identified family member's current educational, work or leisure placement.

Part II was divided into five sections and asked respondents to indicate their emotional, spiritual, social, health, occupational and economic perceptions of their caregiving responsibilities. Section A asked respondents to identify how caring for their family member with a disability had or had not changed certain aspects of their life (e.g., spirituality, altruism). Participants were asked to indicate how these aspects of their life had either "increased," "remained the same," or "had been reduced." Sections B and C probed caregivers' feelings regarding control, fatigue and the social life of their family and how these aspects of their lives had or had not been changed by caregiving responsibilities. Respondents circled one of 4-choices which best matched their perception (e.g., "yes-there was a change," "it is likely there has been a change," "it is likely there has been no change," or "no-there has been no change"). The next sections, Sections D and E, probed the economic impact of caregiving, who in the family provided assistance with care, caregivers' attitude regarding government-sponsored services and supports, and attitudes regarding the future. Respondents circled the 5-choice option that best matched their perception. The last part of the survey asked respondents to write their biggest "gain" and "loss" as a function of providing care (open-ended questions). Figure 1 shows a summary of the survey questions, excluding demographic and open-ended questions.

Results

Differences in Caregivers' Perceptions

This research question attempted to identify similarities and differences in the stressors, perceptions and/or attitudes of caregivers from the two countries. The following are the highest percentage of responses reported for each survey item, by section. *Section A.* Responding to how their level of

spirituality had been influenced by caregiving, the American respondents indicated it had remained the same (48.4%), while Czech respondents indicated that it had increased (49.3%). Indicating how their level of altruism had been influenced, 48.4% of respondents in the United States indicated it had remained the same while 45.8% of the Czech participants indicated so. In reporting how their level of tolerance had been influenced, American respondents reported it had increased (64.5%), while 43.1% of respondents in the Czech Republic indicated that it had increased. Indicating

how their level of peace and serenity had been impacted, respondents in the United States expressed that it had remained the same, while 40.9% of the Czech respondents reported that peace had decreased. Responding to how their level of faith in humanity may have changed, 50% of the American respondents indicated it had remained the same, while 44.0% of respondents in the Czech Republic indicated this response. Noting how their level of life optimism had been influenced, 48.4% of American respondents indicated it had remained the same, while 41.3% of the respondents in the Czech Republic suggested that this aspect of their life had decreased. Responding to how their level of humbleness toward what life brings, 66.7% of the Americans indicated it had increased as 41.8% of the Czech respondents reported the same.

Section B. Responding to whether they felt a loss of control in their lives, 54.8% of respondents from the United States reported that they did “sometimes,” while 51.6% of respondents in the Czech Republic did not answer this question. Fifty-four percent (54.5%) of the American respondents indicated that they “sometimes” experienced depression and despair, while the largest group of respondents in the Czech Republic (29.4%) felt the same. No answer was given to this item by 45.3% of the Czech Republic group. Indicating if they felt fatigue, the highest percentage of respondents in the United States (45.2%) indicated that they did “sometimes” experience fatigue while 34.7% of respondents in the Czech Republic also felt this way. In answering if they were able to enjoy free time, 38.7% of the respondents in the United States indicated that they did “sometimes,” while 29.8% of respondents in the Czech Republic said “yes” they enjoyed their free time and 38.2% did not answer this question. Regarding the ability to rejoice in life, 35.9% of American respondents reported that they were not able to do this, while 24% of Czech respondents indicated that they could “sometimes.” Responding to whether there had been a change in their personal life perspective, 29% of American respondents indicated “no,” while 35.2% of Czech respondents reported there had been no change.

Section C. Reporting whether they perceived their isolation from people had increased as a result of caregiving, 25.8% of American respondents suggested that “yes” it had and the same number reported “no.” Respondents in the Czech Republic (34.5%) indicated that “yes” isolation has increased. Reporting whether their health had deteriorated, 35.5% of American respondents reported “no” to this question, while 25.8% of Czech respondents indicated that their health had “somewhat” gotten worse. In examining if the economic standard of their family had deteriorated, 29% of respondents in the United States revealed that there was “no change,” while 28% of respondents in the Czech Republic indicated that their economic standing had “declined.” Forty-two percent of American respondents in the United States indicated that there had been “no change” in relationships with family members, while 31.1% of respondents in the Czech Republic indicated this response. American respondents

PART II, Section A
Spirituality
Altruism
tolerance toward other people
peace and serenity
faith in humanity
life optimism
humbleness towards what life brings
Section B
loss of control in life
feelings of depression and despair
feelings of great fatigue
loss of ability to enjoy free time
loss of ability to rejoice
loss of personal life perspective
Section C
isolation from other people has increased
state of health has deteriorated
economic standard of family has deteriorated
relations between family members have deteriorated
social life of family has deteriorated
feel enriched by the situation
Section D
who provides most care
help from siblings
help from wider family
Section E
I believe governmental financial support provided to families is sufficient
I believe persons providing care enjoy respect and recognition from my country
I believe the situation of individuals with special needs and the persons providing care for them will continue to improve in my country
I look forward to what the future has to bring

Figure 1. Summarized Items from the Caregivers’ Perceptions Survey

(29%) indicated that the social life of their family had “somewhat changed” while 32% of Czech respondents revealed that “yes their social life had declined.” American respondents (38.7%) reported feeling enriched by their situation and 38.7% percent of the American suggested they felt “somewhat enriched.” Czech respondents (24.9%) indicated that they were not “enriched.”

Section D. In responses to who provided the most care, American respondents (51.6%) indicated that males and females took turns, while 73.3% of respondents in the Czech Republic indicated that the female caregiver provided the majority of care. American respondents (32.3%) indicated that “no” siblings did not help with care, while 42.6% of respondents in the Czech Republic reported feeling this way. Indicating whether the wider family provided assistance with care, 32.3% of American respondents reported “yes,” while 30.7% of Czech respondents reported “no.” Figure 2 shows the ten survey items that revealed a difference in the highest percentage responses between caregivers in the United States and the Czech Republic for Sections A-D of the survey.

Impact of Governmental Services and Supports on Caregivers’ Perceptions

The questions in Section E of the survey attempted to address the impact of governmental support and services on caregivers’ quality of life. Responding to the question which asked if the caregiver believed that governmental financial support to families in their country was adequate, the highest percentage of respondents in the United States (41.9%) indicated that they believed that was the case, while the highest percentage of respondents in the Czech Republic (35.6%) indicated that they did not believe support was adequate. Responding to whether caregivers are given respect and recognition in their country, 75.8% of American respondents indicated “yes,” while 24.8% of the respondents in the Czech Republic indicated a “rather no” to this item. When asked if caregivers believed that the situation for individuals with special needs and the persons who provided their care will continue to improve in their country, 29% of the American respondents indicated “somewhat yes,” while 36% of respondents in the Czech Republic indicated that they “did not know.” When asked if caregivers looked forward to what the future would bring, 29.6% of the respondents in the United States indicated “absolutely,” while 38.8% of Czech caregivers reported they “were afraid of the future.” Figure 3 shows the highest percentage responses to survey items that addressed governmental support and services in the two countries.

Qualitative Responses. This part of the survey allowed respondents to express their opinion in two open-ended questions. The first question asked caregivers to indicate their three “greatest gains from providing care” and the second asked for three “greatest losses from providing care.” Responses were clustered by topic and percentages calculated. Fifty-eight percent of the American caregivers indicated their

most common gain from caregiving involved a renewed positive perspective on life and joy from observing the family member with a disability learn new skills. The largest number of caregivers in the Czech Republic identified their greatest gain to involve “personal gains” such as positive emotions and feelings (31.9%). When identifying their greatest losses from being a caregiver, American respondents most frequently reported strained relationships within and outside the family and a reduction in social or personal time (43%) and others (32%) commented on the financial strain of caring for a family member with a disability. Similarly, respondents in the Czech Republic reported their most common loss as a loss of personal freedom (30.1%).

Discussion

This study found that caregivers of individuals with intellectual disabilities in the United States and the Czech Republic reported similarities and differences in their responses to a survey designed to explore perceptions of their lives, their family’s life, caregiving responsibilities and their country’s willingness to support them and their family member with special needs. In looking at the similarities, caregivers in both the United States and the Czech Republic revealed that their caregiving experiences had increased their feelings of humbleness toward what life brings and their tolerance of others. Both groups indicated that they believed that the isolation of their family had increased, and that they sometimes experienced great fatigue. The majority of respondents, in both countries, reported that their sense of altruism, faith in humanity, and their relationships with family members had remained the same as an outcome of providing care. Further, most respondents noted that their greatest gain from caregiving involved positive personal feelings of enrichment and an increased positive personal perspective.

Several differences were revealed when survey responses were compared. For example, caregivers in the United States noted that their sense of peace and serenity and feeling of life optimism had remained the same while these feelings were described as decreased by caregiving responsibilities by the Czech caregivers. The majority of American caregivers revealed that they were unable to rejoice in life, but Czech caregivers reported being able to do this only sometimes. Spirituality was reported as remaining the same by the Americans and as increased by the Czech group. In terms of their personal life perspective, most American caregivers indicated they did not experience a loss of this while Czech caregivers indicated that their life perspective had been negatively influenced by their responsibilities of caregiving. American respondents reported that their health had not been affected, but Czech caregivers noted their health had been “somewhat” affected. Life optimism was reported as remaining the same for the majority of American caregivers, yet was reported as decreased for most Czech care providers. While the family’s social life was reported as “somewhat” worse because of caregiving demands by the American group,

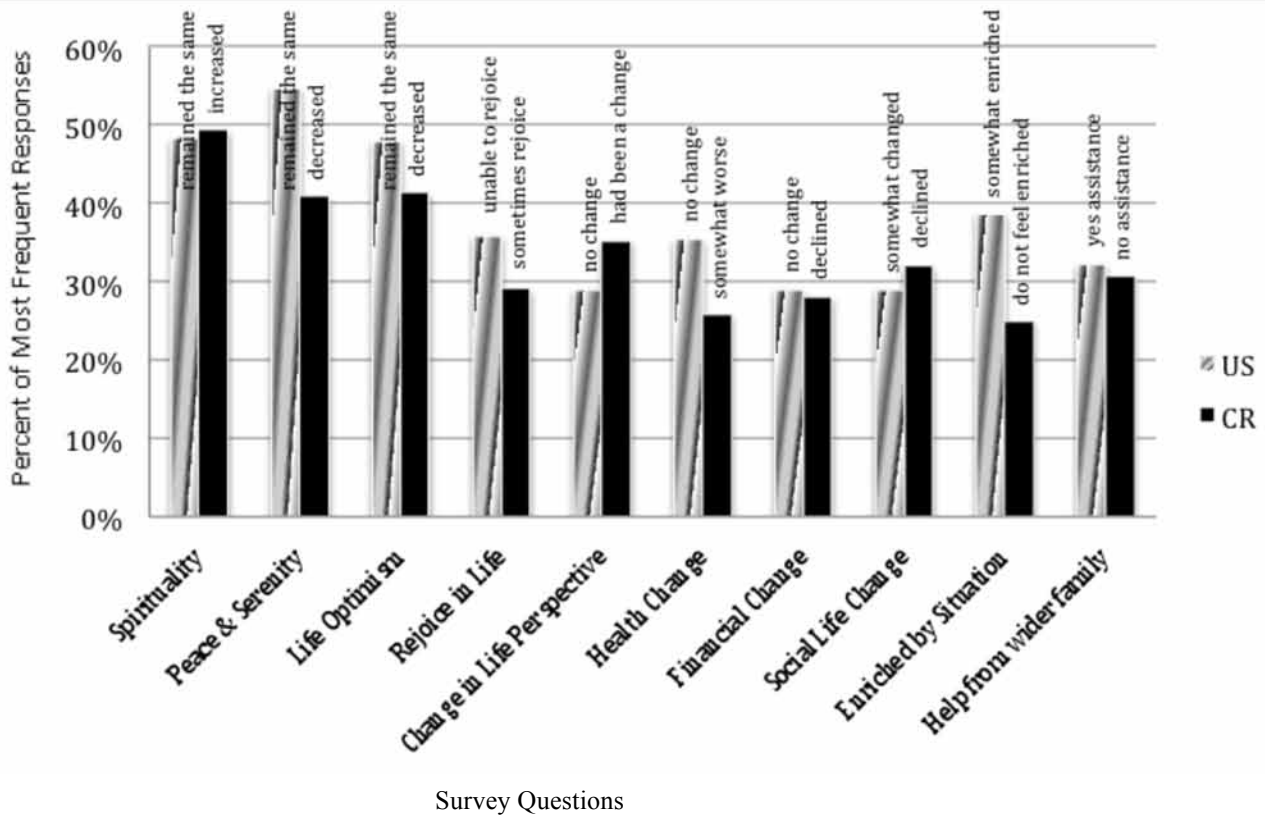


Figure 2. Differences in the Most Common Responses to Survey Items Between Caregivers in the United States and in the Czech Republic.

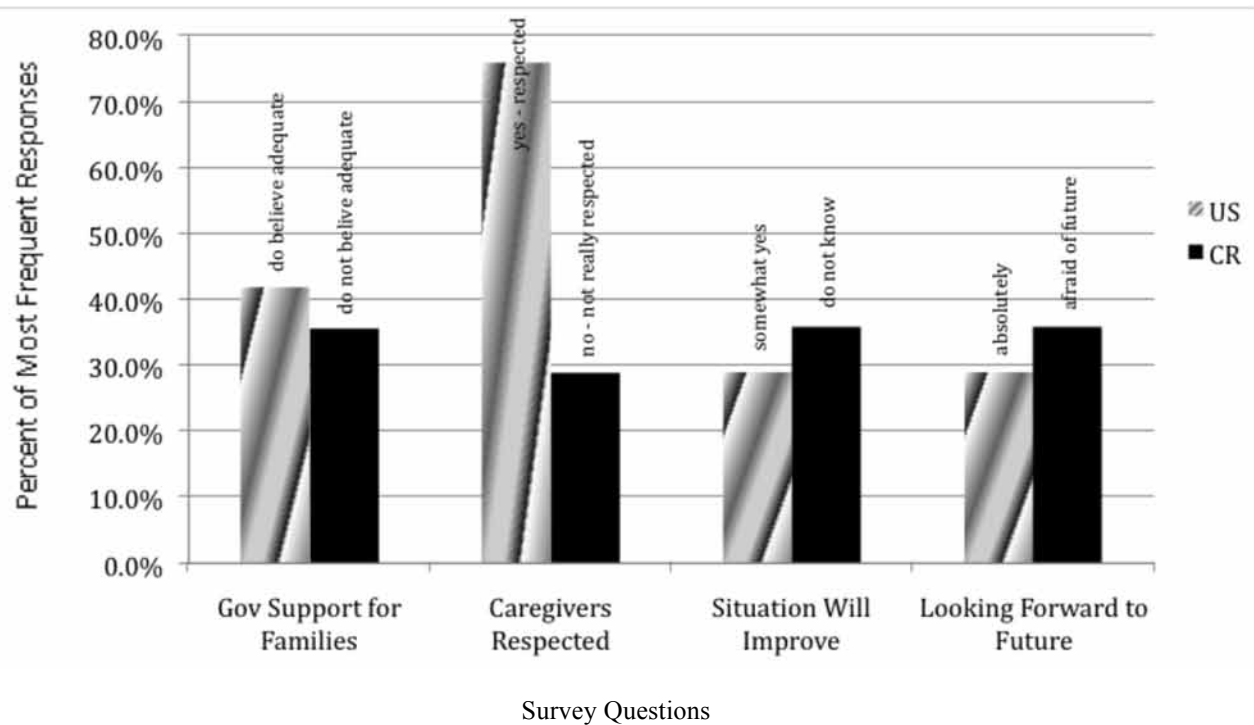


Figure 3. Differences in Caregivers' Most Common Survey Responses to Governmental Support and Services Survey Items in the United States and Czech Republic.

the Czech group indicated that their social life as a family was indeed worse. Most of the U.S. caregivers indicated that they felt “somewhat” enriched by their situation while the Czech group commented they did not feel enriched by caregiving tasks.

It seems clear that cultural differences account for some of the differences found. For instance, respondents in the United States indicated that both the male/father figure and female/mother figure in the home took turns providing care (52%). In contrast, women were reported as the principal caregivers in the Czech Republic (73%). Family practices in the United States, as a general rule, may be described as more egalitarian in terms of parental child rearing responsibilities than those in the Czech Republic so this outcome may not be surprising. Interestingly, most of the American and Czech caregivers noted that siblings did not provide significant assistance with caregiving of family members with disabilities in their families (U.S. 33%; Czech Republic. 47%). But, American caregivers revealed that extended family members were helpful. Most Czech caregivers noted that extended family members were not helpful. Having shared parenting and caregiving responsibilities, as well as assistance from individuals outside the nuclear family, would seem to have a strong positive influence on the quality of life of caregivers living in the United States. It may be that American extended family members and others outside the family are more willing to provide assistance because there is less stigma associated with intellectual disabilities in that country. For nearly forty years, governmental services and inclusion into nearly all aspects of daily life have been commonplace in the United States. For this reason, immediate family members may be more willing to seek assistance from extended family members (Sandler, Warren, & Raver, 1995), and extended family members may be more willing to provide it.

It was uncommon for the American respondents in this study to omit answering a survey item. However, respondents from the Czech Republic did not answer about 20% of the items and occasionally, no answer was the most common response to an item. The omitted items tended to be those that dealt with what may be described as more personal information such as one’s ability to enjoy free time, feelings of depression and despair, feelings of loss of control and the ability to rejoice in life. It may be the caregivers in the Czech Republic, who have enjoyed a shorter history of freedom of speech, may have felt less comfortable answering these questions, fearing formal or informal reprisals to their child or family.

Effect of Governmental Support on Caregivers’ Perceptions of Quality of Life

The second research question in this study dealt with families’ perceptions of governmental support and how this may have influenced their quality of life. Although the majority of American caregivers answered the survey question

by indicating that governmental supports were adequate, many wrote that financial pressures were one of the significant “losses” of being a caregiver. In fact, some caregivers wrote that the American government was *not* doing all that it should financially for families, particularly in helping pay for necessary therapies. In contrast, most Czech caregivers expressed a concern about the adequacy of their government’s supports on this survey item, but did not mention financial needs in the open-ended question dealing with “losses.” In regard to how persons who provided care were respected and/or recognized, there were clear differences of opinions in the two countries. A large portion of the American group answered that they believed caregivers were respected (76%), but the majority response for the Czech group was that this statement was “not really true” (29%).

Vivid differences in how the future was viewed were also expressed. For example, 29% of the American caregivers indicated that they thought that the situation for individuals with special needs and the persons who provided their care would “somewhat” improve. However, the caregivers from the Czech Republic said they did not know if improvement would occur. Additionally, the majority of caregivers in the United States noted that they were “absolutely” looking forward to the future, while the majority of Czech caregivers expressed that they were afraid of what the future could bring. Only about 10% of the American respondents reported feeling this way. It may be that these responses are linked to families’ worries that as government budgets are tightened in a weak economy, services they have learned to depend upon may be in reduced, or even eliminated. Because of a longer history of protecting and supporting the disabled in the United States, the American group may have felt more confident in their knowledge that although services may be reduced, it is unlikely that services and supports would be eliminated altogether. Caregivers in the Czech Republic may fear that the gains they have made in the last decade could be taken away from them.

American Governmental Supports. All students with intellectual disabilities in the United States attend mandatory, free public schools which are supposed to meet their individual needs (Individuals with Disabilities Education Improvement Act, 2004). Many caregivers are eligible or may receive Social Security benefits such as Supplemental Security Income (SSI) or Childhood Disability Benefits (CDB) (Brooke & McDonough, 2008). For children under the age of 18 years, SSI is meant for families with extremely limited income that are providing care for an individual with a disability (Social Security Administration, 2007). If there are no other sources of income, the family will live below American poverty standards since the money is intended to strictly cover food and shelter (Ferrell, Brooke, Kregel, & Getzel, 2002). Individual and family earnings affect eligibility for these programs. The Ticket to Work and Work Incentives Improvement Act of 1999 was crafted to remove disincentives to employment by individuals with disabilities who are over

the age of 21 years. As of 2000, health care coverage was expanded to include more people with disabilities between the ages of 16 and 64 and those who return to work. Despite these supports, more than half of the American caregivers who responded to the open-ended “losses” question, expressed concerns about their family’s financial stability and commented on the financial burden they experienced.

Czech Republic Governmental Supports. The Ministry of Education, Youth and Sport provides financing for compensatory technological equipment, counseling and resource centers that provide special educational support for individuals with special needs. Financial support is available to qualified families (Special Needs Education with the Educational System: Czech Republic, 2009). This support may include paid maternity leave, a social living and care subsidy, and health care when a family qualifies. Assistance is based on the family’s income level and a child’s age. Most Czech respondents indicated that present governmental supports were insufficient but few mentioned financial need in the “losses” question.

General Implications

In general, the caregivers in the Czech Republic may be characterized as slightly less positive in their outlook than the American caregivers since they reported a decrease in life optimism, less ability to enjoy free time, and that they did not feel enriched by providing care for an individual with special needs. American caregivers noted that they felt respected and acknowledged while those in the Czech Republic did not which undoubtedly affected the Czech respondents’ perception of their quality of life. It may be that these findings may also be an outcome of the populations to whom caregivers were providing care. That is, the majority of Czech caregivers were providing care to individuals who they described as falling into the severe-profound mental retardation range while the majority of those receiving care in the United States were described as functioning within the mild-moderate range of intellectual disabilities. It would follow that providing care to individuals with lower levels of personal independence could be more physically draining and demanding, fostering less positive perceptions. Additionally, the individuals receiving care in the Czech Republic tended to be older than those in the United States.

Several factors affect the degree to which the results of this study may be generalized. First, respondents from the United States resided in the same geographical area and were a small sample; those in the Czech Republic represented families from across the country. Second, the majority of the respondents were female. Third, a large portion of the respondents were married or lived with a partner that may have influenced their responses. Finally, although most individuals receiving care were below the age of 20, different results may have been generated if all family members had been of similar age and received comparable services. More research is needed which evaluates caregivers’ quality of life issues and seeks to

develop and identify family-centered supports that may promote the coping capacities of caregivers based on these evaluations. Further, future research needs to focus on the development of standardized evaluation tools which may give caregivers, and other constituents, a voice in shaping the services provided. This is particularly critical in countries in which parents and family members have fewer rights.

The caregivers in this study made it clear that caring for an individual with an intellectual disability presented rewards as well as difficulties. This outcome has been reported by others in the United States (Grant & Whittell, 2000; Heiman, 2002; Judge, 1998). The results of the present study suggest that although caregivers in the two countries reported many strong feelings such as increased fatigue, the majority in both countries were also able to appreciate the positive aspects associated with their caregiving responsibilities such as increased humbleness. Equally informative is that both groups revealed similar advantages (e.g., increased positive personal feelings) and disadvantages from providing care (e.g., loss of personal and family freedom and disruption in family relationships). Bailey and colleagues (1998) and others (e.g., Purcell, Turnbull, & Jackson, 2006; Wallender, Schmidt, & Koot, 2001) have asserted that family quality of life should be used as a determinant of the appropriateness of services governments and service providers offer families. In the past in the United States, services have been based on lawmakers’ best guesses and informal polling of the stakeholders. Attempting to gather more quantifiable data from stakeholders should increase the government’s ability to make informed decision-making.

It is generally accepted that being a caregiver of an individual with a disability can involve time, energy, and frequent disruption of family routines, particularly when health concerns are involved (Floyd & Gallagher, 1997; Murphy et al., 2006; Schultz & Quitner, 1998). Parish and associates (2008), in reporting data from a national survey conducted in the United States, found more material hardship among families raising children with disabilities when they were compared to families raising typical children, primarily due to the costs of therapies and loss of income. The Parish study and this one suggest that current government services and programs may be inadequate in addressing the material, emotional and relationship-based hardships experienced by families. Although more research is needed to identify the specific strains families face, it is evident that caregivers need personalized supports to assist them in managing and meeting the needs of the individuals with a disability for whom they are providing care.

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Does Journaling Effectively Reduce Psychological Distress of Korean-American Mothers of Children with Developmental Disabilities?

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Abstract

This study explored the extent to which mothers experienced depressive symptoms associated with having a child with a disability and if journal writing would reduce maternal distress. Thirty-eight Korean-American mothers of children with disabilities filled out pretest data using CES-D (Radloff, 1977) and IES-R (Weiss & Marmar, 1997). Based on the results of CES-D pretest data, the participants were randomly assigned to either the experimental or the control group. Journal writing was implemented with the experimental group while the control group was placed on a waiting list. After a four-week post intervention, the participants filled out posttest data using the same assessments. The results revealed that approximately one-half of the participants experienced clinically depressive symptoms and that journal writing did not reduce maternal distress. The discussion focuses on several effective strategies for future research to consider in implementing journal writing with mothers of children with disabilities in Korean and other Asian cultures.

Having a child with a disability has been considered a stressful experience and potentially traumatic for parents from many cultural backgrounds (Barry & Singer, 2001; Cho, Singer, & Brenner, 2000; Ryan & Smith, 1989). Being aware of culture specific needs among diverse families of children with disabilities can assist professionals in supporting the families. However, little is known about how Asian-American families in the U.S. deal with the complex and often stressful circumstances associated with raising a child with a disability.

A few studies have identified the ways Asian-American families respond to the challenge associated with having a child with a disability (Cho et al., 2000; Raghavan, Weisner, & Patel, 1999; Ryan & Smith, 1989). For example, a study by Ryan and Smith (1989) found that low-income Chinese-American parents of children with disabilities experienced various negative emotions such as depression, confusion, frustration, guilt, anger, powerlessness, and a sense of being overwhelmed or embarrassed. Similarly, a study with middle-income South Asian-American parents reported that finding quality childcare and assuming on-going caretaking responsibilities for their children with disabilities presented the greatest difficulty to these families, and resulted in them feeling lonely and socially unsupported (Raghavan et al., 1999). The responses of middle-to-high income Korean-American parents of children with disabilities in a study by Cho et al. indicated that they experienced high levels of distress and other negative emotions.

Parental Depression and Conventional Intervention

Consequences of untreated depression on the depressed caregivers of children with or without disabilities

have been documented and the outcomes are detrimental to both the depressed individuals and their offspring. Individuals experiencing depression often suffer memory loss (Lauer, Giordani, Boivin, & Halle, 1994), inability to recall information (Reidy & Richards, 1997), and deficits in cognitive ability (Austin, Ross, Murray, & O'Carroll, 1992). Distressed parents of children with disabilities are more likely to use avoidance coping skills (Cheng & Tang, 1995), have a low level of hopefulness about their child's future (Galvin, 2001), and have difficulty learning or recalling information from parent training (Singer, 2000). Parental depression has also been found to have negative impacts on the development of their children. For example, Downey and Coyne (1990) reported that compared to children of non-depressed caregivers, school-age children of depressed caregivers generally show higher levels of both externalizing and internalizing symptoms, higher levels of treatment for psychiatric disturbance, higher levels of functional impairment, deficits in academic and social competence that are not due to intellectual limitations, and poor physical health. Similarly, parental depression has a strong correlation with infants' and toddlers' poor adjustment (Goodman, 1987; Sameroff, Barocas, & Seifer, 1984), and depression as well as antisocial behavior (Gaensbauer, Harmon, Cytryn, & KcKnew, 1984; Zahn-Waxler, Mayfield, Radke-Yarrow, McKnew, Cytryn, & Davenport, 1988). In essence, major depression in mothers has been found to compromise their ability to respond to their children and places children at risk for psychopathology and developmental difficulties (Downey & Coyne, 1990).

Although depression among Korean-American parents of children with disabilities is rarely known, a study by Kim (2007) provides an insight into the impact of depression on parenting. Using a sample of 408 mothers in Korea, Kim found that socio-environmental stress could result in

depression and a low level of parenting self-efficacy amongst the mothers. That is, the lower the income the more vulnerable the mother was to distress. However, maternal stress related to parenting was mediated by the mental health of low-income mothers. Based on Kim's study (2007), it is suggested that to maximize effective parenting among Korean-American mothers of children with disabilities, under high-stress, their psychological well-being must first be addressed. Psychologically healthy, competent caregivers may in turn be able to provide quality parenting and better advocacy for their children with disabilities. Thus, a culturally sensitive intervention must be developed to assist these mothers to cope with their emotional issues, develop their own coping strategies, and regain a sense of their parenting competency.

Traditional psychotherapy and counseling often do not address the psychological needs of Asian people (Berg, & Jaya, 1993; Chin, Liem, Ham, & Hong, 1993; Leong & Lau, 2001; Sue, 1989; Zane, Enomoto, & Chun, 1994). In particular, Korean immigrants in the U.S. have been found to have higher levels of depressive symptoms compared to other Asian groups (Hurh & Kim, 1990; Noh & Avison, 1992). However, Korean immigrants rarely access professional help, nor do they seek information on their own about mental illness. Instead, they tend to cope with their depression through endurance, patience, and religion (Bernstein, Lee, Park, & Jyoung, 2008).

Several researchers have theorized that under-utilization of counseling and psychotherapy is substantially embedded in Asian cultural values and beliefs. For example, because practicing self-discipline and controlling strong feelings is considered a cultural virtue (Chan & Lee, 2004), Asian-Americans may have a general distrust of formal services (Weisman & Ryan, 1981) or at least may not consider formal counseling and psychotherapeutic services as the first option to resolve personal and family issues (Berg & Jaya, 1993). The stigma associated with mental illness in traditional Asian cultures may also prevent them from seeking counseling and psychotherapeutic services (Kim & Rew, 1994). Thus, there is need for identifying a culturally responsive intervention for Asian people, particularly parents of children with disabilities.

Journal Writing Intervention

Journal writing has proven to be an effective intervention strategy in counseling and psychology. Pennebaker (1997) theorized that emotional expressions of stressful or traumatic events through brief journaling for 15-20 minutes per day, three or four days in a row produce positive psychological and physical benefits. He stated that written self-disclosure enables the individual to feel a sense of control over life-threatening experiences and allows for reflection and cognitive restructuring processes to occur. As a consequence of this personal narrative experience, negative emotions are released (Lepore, Greenberg, Bruno, & Smyth, 2002) and cognitive resources are freed up, which result in promoting problem-solving and coping skills (Klein, 2002).

Overall, the findings to do with journal writing are positive with some exceptions (Schwartz & Drotar, 2004). For example, journaling has decreased perceived physical illnesses (e.g., Esterling, L'Abate, Murray, & Pennebaker, 1999; Francis & Pennebaker, 1992), reduced psychological distress (Barry & Singer, 2001), and increased both physical and psychological benefits (Alpers, Winzelberg, Classen, Dev, Koopman, Roberts et al., 2005; Lepore et al., 2002; Pennebaker & Beall, 1986; Pennebaker & Francis, 1996; Thompson & Gustafson, 1996).

Journal writing was recently introduced to the field of special education and the findings are inconclusive. For example, Barry and Singer (2001) applied a journal writing intervention to mothers of infants staying in a neonatal intensive care unit (NICU). Using an experimental-comparison group design, the authors reported that journal writing significantly reduced the levels of psychological distress of mothers in the experimental group. By contrast, Schwartz and Drotar (2004) reported conflicting results. Using a similar experimental-comparison group design with caregivers of children and adolescents with chronic illness, the authors found that the caregivers in the experimental group reported a higher level of psychological distress on a posttest, following a journal writing intervention period. Based on these studies, the question still remains as to whether journal writing would effectively reduce levels of parental distress.

While the literature is contradictory, journal writing appears to have several qualities that may be culturally relevant to Asian parents. For example, journal writing allows for emotional expression in a personal and non-threatening manner. Thus, the intervention goals can be accomplished while not damaging the cultural values of controlling one's own feelings and difficulties, or family face-saving (preserving self-respect) issues which is highly valued by most Asians. In addition, intervention recipients do not need to attend therapeutic sessions that take place in the context of interpersonal relationships between the therapist and client, and require face-to-face self-disclosures that may be incongruent with cultural norms. Further, recipients do not need to deal with logistics such as babysitting arrangements, transportation, or a translation issue, which are often required for attending conventional therapy and become an additional source of stress. Finally, intervention duration may be another crucial element to determine the success of an intervention particularly for caregivers raising young children. When conventional intervention requires attending a number of sessions, clients may be unable to participate in enough sessions to achieve a successful outcome. As a result, the effectiveness of the intervention may decrease. In fact, Asian-Americans show a higher rate of premature termination when in treatment for depression compared with other ethnic groups (Leong & Lau, 2001).

Theoretical Framework for Family Adaptation and Journal Writing

Several theoretical frameworks for family adaptation and journal writing intervention guided this research. First, based on developmental stages of adaptation theory, in the early years after the birth and diagnosis of a child with a disability, mothers are likely to undergo a process of adaptation that has both cognitive and emotional elements that may lead to the emergence of positive views and feelings (Behr & Murphy, 1993; Summers, Behr, & Turnbull, 1989; Taylor, 1983). This stage of adaptation opens a window of opportunity for positive intervention effects to occur. Second, the simple act of expressing the most traumatic experiences on an affective level may produce positive adaptation and health benefits (Pennebaker, 1985). Finally, based on personal constructivist theory, persons can modify their way of understanding an experience by changing the way they use internal language (Monk, Winslade, Crocket, & Epston, 1997). Dewey (1958) described language as the vehicle by which we bring order and meaning to our thoughts. Thus, the act of using private language provides coherence and organization to our personal understanding of difficult situations in a culturally meaningful way (Bruner & Lucariello, 1989).

The existing literature on the adaptation of Korean-American mothers to their children with disabilities reveals some methodological issues in light of research methods and sampling. For example, no quantitative study on Korean-American mothers is yet available. In addition, culturally diverse populations have been excluded from the studies that examined effectiveness of journal writing with parents with disabilities. Therefore, this present study aimed to address two questions: (a) To what extent do Korean-American mothers experience depressive symptoms associated with raising a young child with a disability? and (b) Does a journal writing intervention effectively decrease levels of depressive symptoms of Korean-American mothers? Consistent with prior literature, we hypothesized that at least one-third of Korean-American mothers, as a group, would report depressive symptoms beyond the clinical cutoff score at a pretest measured by the Center for Epidemiologic Studies-Depression Scale (CES-D, Radloff, 1977). We also anticipated that the mothers in the journal writing experimental group would demonstrate lower levels of depressive symptoms at a posttest of the CES-D and the Impact of Events Scale-Revised (IES-R, Weiss & Marmar, 1997) following a four week post intervention period, when compared to the mothers in the control group.

Method

Participants

The participants were 38 Korean-American mothers whose children were currently receiving or had exited early intervention services in New York City and volunteered to

participate in the study. Potential participants had to meet two conditions. First, participants have children with developmental delays or disabilities, either of which was diagnosed within two years of the onset of disability when a contact was made for this study. Second, participants did not attend counseling and psychotherapy for psychological distress associated with their children with disabilities. Fifty-two mothers who met both conditions agreed to participate in the study. While a journal writing intervention was being implemented, 14 mothers (27%) dropped out of the study because of their busy schedules, which resulted in 38 participants (18 in the experimental group and 20 in the control group; see Table 1).

Table 1

Participants' Demographic Information

Variable	Experimental (<i>n</i> = 18)	Control (<i>n</i> = 20)
Maternal Age: <i>M</i> (<i>SD</i>)	35.76 (3.99)*	32.69 (2.93)
Maternal Education: <i>M</i> (<i>SD</i>)	14.61 (2.09)	14.25 (1.80)
Maternal English Proficiency ^a : <i>M</i> (<i>SD</i>)	1.53 (0.62)	1.65 (0.49)
Maternal U.S. Residency in Years: <i>M</i> (<i>SD</i>)	9.95 (6.12)	6.85 (3.88)
Household Income: %		
Less than \$29,999	28	47
\$30,000 - \$44,999	44	27
\$45,000 - \$59,999	11	21
\$60,000 - \$74,999	6	0
More than \$75,000	11	5
Child Age: <i>M</i> (<i>SD</i>)	2.93 (1.10)	2.28 (1.20)
Child Gender: %		
Male	65	71
Female	35	29
Child Diagnosis: %		
Pervasive	41	25
Developmental Disorder		
Speech/Language	6	25
Disorders		
Developmental Delays	35	37
Others	18	13

Note: ^a Judgments were made on a three-point scale (1 = low, 3 = fluent). **p* < .05.

The Center for Epidemiologic Studies-Depression Scale (CES-D, Radloff, 1977), measures depressive symptoms. This self-report measure has been widely used in community mental health epidemiological studies to examine one aspect of psychosocial well-being. It has also been used to assess the impact of treatments on depressive symptoms. It consists of 20 items representing four symptom clusters which include negative affect, positive affect, interpersonal problems, and somatic symptoms. Responses are scored on a four-point scale, ranging from zero being "rarely or none of the time" to three being "most or all of the time." The cutoff point for possible clinical depression is a score of 16. The CES-D (Radloff, 1977) demonstrates high internal consistency, with alphas of .89 and .90. The scale has been translated into the Korean language and several studies reported that the validity and reliability of the translated scale were sound (Cho, Singer, & Brenner, 2003; Noh & Avison, 1996; Noh, Speechley, Kaspar, & Wu, 1992).

Impact of Events Scale-Revised (IES-R, Weiss & Marmar, 1997). The IES-R is a brief self-report assessment consisting of 22 items (Weiss & Marmar, 1997). It is designed to measure three broad domains of response to trauma: *intrusion*, *avoidance* and *hyperarousal* that are symptoms of traumatic stress. *Intrusion* is the reoccurrence of memories of, or memories related to, the trauma. *Avoidance* includes numbness and the absence of any thought or feeling about the traumatic experience. *Hyperarousal* refers to the physiological states associated with the trauma response including lack of sleep, difficulty concentrating, anger, and more (Weiss & Marmar, 1997). The IES-R targets levels of symptoms in the past seven days. Responses are scored on a 4-point scale, ranging from zero (not at all) to three (often). The IES-R (Weiss & Marmar, 1997) demonstrates sound reliability and validity. The internal consistency of the three subscales was *intrusion* alphas ranging from .87 to .92, *avoidance* alphas ranging from .84 to .86, and *hyperarousal* alphas ranging from .79 to .90 (Briere, 1997). The correlation coefficients were .94 for *intrusion*, .89 for *avoidance*, and .92 for *hyperarousal* subscale (Weiss & Marmar, 1997). This study used the Impact of Events Scale-Revised to measure levels of parental traumatic stress because many parents view having a child with a disability as a traumatic experience (Barry & Singer, 2001; Cho et al., 2000; Ryan & Smith, 1989).

Reliability of the Korean translated IES-R on the pretest with a Korean-American sample was measured. Cronbach's coefficient alphas were .92 for the total, .85 for *avoidance* subscale, .90 for *intrusion* subscale, and .86 for *hyperarousal* subscale. The correlation matrix also indicates that the three subscales were highly correlated with the IES-R total, with a range from .75 to .91 at $p = .01$. In addition, convergent validity was estimated on the CES-D total and the subscales of the IES-R and its total. The results yielded sound correlations among the variables (.58 - .83) at $p = .01$, except the CES-D by *avoidance* (.25). Overall, the results indicated that the IES-

R is a reliable measure to assess response to trauma and distress among the sample of Korean-American mothers of young children.

Instructions for Journal Writing Intervention to Parents. Journal writing instructions were slightly modified from those used in Barry and Singer's (2001) study of parents of infants born with a low-birth weight. The instructions guided participants to write in the provided journal for approximately 20 minutes a day on four days in a row about the most emotional and upsetting experiences of having a child with a disability that may have occurred during their pregnancy, during the diagnosis, and until the present day. To help the participants begin to write, the instructions provided several guiding questions. Some example questions included: "What were the most emotional or troubling experiences during or after the diagnosis? Describe what these experiences were and write about your deepest thoughts and feelings about those experiences in great detail." "Have you learned anything as a result of the experience? If so, what have you learned from the experience?"

Procedure

For the participants with limited English proficiency, all the measures and journal writing instructions were translated into Korean by the first author who is fluent in Korean and English, and then translated back to English by an early intervention coordinator who is bilingual in Korean and English and has a Master's degree in special education to ensure the translation validity (Cho et al., 2000). Less than ten discrepancies in the IES-R and journal writing instructions occurred between the translated and back translated versions. The two translators discussed the discrepancies in terms of vocabulary and idiomatic equivalence (Behling & Law, 2000; Brislin, 1970) until complete agreement was reached. Participants were informed that the research protocol was available in both English and Korean.

The journal writing intervention was implemented as Barry and Singer (2001) suggested in their study. A letter describing the purpose of the proposed project was mailed to potential study participants by the staff at two early intervention programs in New York City with a stamped return postcard. After a participant's informed consent form was received, the author contacted the participants by phone to explain the study in detail. Then the pretest materials that included the CES-D (Radloff, 1977), IES-R (Weiss & Marmar, 1997), and a demographic information form were mailed. Upon receiving the completed pretest materials, the participants were rank-ordered and matched in pairs by their score on the CES-D to ensure the similarity of the two groups. Participants in each matched pair were then randomly assigned to either the journal writing intervention group or to the control group. The intervention group received journal writing notebooks and written instructions designed to help them write about stressful events associated with raising a child with a disability, while the control group were placed on the waiting list. They were

told that a journal writing intervention would be provided after the posttest was completed. Prior to mailing journal writing notebooks, a serial number was assigned to each notebook so that participants could freely express their stressful life experience without being concerned about the possibility of their privacy being disclosed.

While journal writing interventions were implemented, the author made frequent contacts to the study participants via phone or email: (1) to reduce subject attrition, (2) to encourage the participants to follow the research protocol appropriately, and (3) to answer possible questions regarding the intervention and instruments. Posttest data including the CES-D (Radloff, 1977) and IES-R (Weiss & Marmar, 1997) were mailed to all participants in both groups four weeks after the journals were returned (Barry & Singer, 2001). All the distributed materials including introductory letters and pretest, journal writing intervention instructions, and posttest materials were printed in English and Korean. All, but two participants filled out the Korean version of the materials and wrote their journals in Korean.

Data analysis

Equivalence of the experimental and control groups on demographic variables was established using independent sample *t*-tests and χ^2 tests. The *t*-test results show the groups differed only in age, with the experimental group being older than the control group, $t(36) = 2.632, p = .01$ (two-tailed). The age difference, however, accounted for an insignificant proportion of variance and thus, age was not used in subsequent analyses. The χ^2 tests on family income, child gender, child diagnosis variables revealed no significant difference between the groups. Finally, all participants were married except two (divorced) in the experimental group. The overall descriptive analyses suggest that the two groups were fairly comparable.

Prior testing the two hypotheses, a one-way ANOVA was performed on the CES-D, IES-R total as well as IES-R subscales at pretest in order to measure the equivalence of the two groups (that were randomly assigned) at the pretest. In addition, Cohen's *d* statistic and a multivariate analysis followed by a univariate analysis were performed. Using an effect size calculator, *d* statistic was computed to obtain journal writing intervention effects (Becker, 2000). Note that unlike traditional inferential statistics, *d* statistic does not depend on a sample size when comparing mean differences between groups. With a small number of participants, as in this study, inferential statistical tests can produce misleading results. Finally, a series of multivariate analyses was performed on the CES-D posttest, IES-R posttest total and its three subscales, with group as a fixed variable, and pretest scores of the CES-D and IES-R as covariates.

Results

The first hypothesis of the study was that at least one-third of Korean-American mothers, as a group, would report

depressive symptoms beyond the clinical cutoff score at a pretest measured by the Center for Epidemiologic Studies-Depression Scale (CES-D, Radloff, 1977). The descriptive analyses revealed that 44% of the total group of participants reported depressive symptoms beyond the clinical cutoff score measured by the CES-D. While 41% in the experimental group reported experiencing clinically depressive symptoms, 47% in the control group fell within the clinical level. The results of a χ^2 test revealed no difference between the two groups. Based on this result, the first hypothesis was accepted.

The second hypothesis was that the experimental group would demonstrate lower levels of depressive symptoms at a posttest of the CES-D and the IES-R when compared to the control group. The results of an one-way ANOVA on the CES-D yielded an $F(1, 36) = .140, p = .711$, indicating that the difference on the CES-D between two groups was not significant. The results on the IES-R produced an $F(1, 36) = .012, p = .913$, again indicating that the two groups did not differ. The results on the three subscales showed no difference between the two groups for *avoidance* ($F[1, 36] = .824, p = .370$), *intrusion* ($F[1, 36] = .179, p = .674$), and *hyperarousal* ($F[1, 36] = .672, p = .418$).

Table 2 presents the means and standard deviations of the two dependent measures (CES-D and IES-R) at pretest and posttest as well as *d* statistic. As the table indicates, the *d* statistic results showed that the effect sizes of the differences between groups at the posttest for the two dependent measures were in the range from .05 to -.25, indicating no substantial mean differences between the experimental and control group. The multivariate analysis results yielded an omnibus $F(2, 33) = .254, p = .777$, with the CES-D producing an $F = 2.596, p = .09$ and the IES-R an $F = 6.545, p = .004$. The result on the CES-D indicates that the level of depressive symptoms of both the experimental and control groups at the posttest did not differ from that of the pretest scores. The multivariate results on the IES-R were exclusively explained by a significant univariate effect ($F[6, 1142] = 1.94, p = .07$) for the IES-R. The results on the three subscales of the IES-R yielded an omnibus $F(3, 31) = .287, p = .834$ with *avoidance* subscale producing an $F = 11.002, p = .000$, *intrusion* subscale an $F = .1998, p = .135$, and *hyperarousal* subscale an $F = 8.261, p = .000$. However, the results of univariate analyses revealed that the significance for *avoidance* subscale was exclusively explained by *avoidance* pretest ($F[1, 33] = 13.659, p = .001$) and for *hyperarousal* subscale by *hyperarousal* pretest ($F[1, 33] = 9.477, p = .004$). The overall results indicate no difference between the experimental and control group in reducing the level of distress at the posttest of the IES-R subscales.

Discussion

This study aimed to test two hypotheses: (1) that more than one-third of the participants would report clinically depressive symptoms at the pretest as measured by the CES-D and (2) that a journal writing intervention would effectively reduce the

Table 2

Means and Standard Deviations of the CES-D and IES-R at Pretest and Posttest, and d Statistic

Measure	Experimental (n = 18)		Control (n = 20)		d
	Pretest M (SD)	Posttest M (SD)	Pretest M (SD)	Posttest M (SD)	
CES-D	15.89 (7.26)	17.06 (7.46)	13.75 (9.32)	14.55 (10.83)	.14
IES-R	29.28 (14.45)	27.83 (16.38)	21.40 (16.06)	21.25 (18.72)	-.02
Avoidance	11.56 (6.56)	10.72 (6.88)	7.15 (4.61)	8.25 (6.27)	-.25
Intrusion	11.06 (6.15)	10.33 (6.81)	8.70 (8.27)	8.35 (8.72)	.07
Hyper-arousal	6.67 (3.79)	6.77 (4.57)	5.55 (5.77)	4.65 (6.36)	.05

depressive symptoms of the parents in the experimental group measured by CED-D and IES-R. The results support the first hypothesis: 44% of the participants rated depressive symptoms beyond the clinical cutoff point, indicating that they rated being clinically depressed. This result is consistent with Singer's (2000) meta-analysis study, which found that a significant proportion of mothers (30-50%) of children with disabilities exceeded clinical cutoff points for major depression.

Compared to the Korean-American sample in a study by Cho et al. (2003), a much higher percent of participants in the present study reported clinically depressive symptoms. There are several possible explanations for the difference in results. Unlike the previous study, participation for this study was limited to mothers of children whose diagnoses were obtained within two years of commencing the intervention. As the children's mean ages indicate in Table 1, children of the participants were much younger ($M = 2.6$ years) than that ($M = 5.4$ years) of the Cho et al. (2003) study. Accepting the recent diagnoses of their children may put the participants under tremendous distress. Korean-American mothers of older children in a prior study (Cho et al., 2000) reported that their depressive symptoms were much more intense near the time of the initial diagnoses of their children and that their depressive symptoms decreased as time passed. This previous finding provided an explanation for why more participants in the present study reported clinically depressive symptoms.

The comparison of the findings of this present study of Korean-American mothers of young children to prior findings of the same ethnic mothers of older children supports various theories of the adaptation process of families in mainstream U.S. society (Behr & Muphy, 1993; Summers, Behr, & Turnbull, 1989; Taylor, 1983). According to these theories, mothers are likely to undergo a process of adaptation that has both cognitive and emotional elements and often resolves into positive views and feelings.

The different results between the current study and a previous study by Cho et al. (2003) with Korean-American mothers may also be due to different demographic characteristics. For example, the majority of the sample in the Cho et al. (2003) study was in the middle-to-high SES and

lived in the greater Los Angeles area. By contrast, the sample in the current study was in the low-to-middle SES status living in New York. It is speculated that dealing with the recently identified issues of their children, living in an extremely fast-paced city, and lacking economic resources may contribute to experiencing more depressive symptoms among mothers in the current study. Economic strain is reported to be linked to low levels of parenting self-efficacy among Korean mothers with lower parenting self-efficacy being associated with a high level of maternal depression (Kim, 2007). Acculturation level may have contributed to the high level of depressive symptoms among the participants in this study is their acculturation level. Studies have reported that low acculturation is a significant risk factor for depressive symptoms among immigrants to the U.S. (Chiriboga, Black, Aranda, & Markides, 2002; Jang, Kim, & Chiriboga, 2005). In the current study, 88% of the participants asked for the protocol in Korean and their mean U.S. residency was 9.95 years for the experimental group and 6.85 years for the control group. The literature indicates that English proficiency is one important measure of acculturation level (Jang, Kim, Chiriboga, & King-Kallimanis, 2007; Ying, 1995). Based on the findings in this study, it is suggested that early intervention professionals need to be aware that Korean-American mothers of young children lacking economic resources, having low English proficiency, and being in the process of accepting their children's diagnoses are much more vulnerable to depressive symptoms than the same ethnic mothers of older children with disabilities. Professionals also need to be aware that Korean-American mothers need to receive culturally appropriate interventions for their psychological issues.

Contrary to literature supporting the psychological benefits of journal writing, this study did not support our second hypothesis that the journal writing experimental group would report lower levels of depressive symptoms on a posttest. This result supports Schwartz and Drotar's (2004) study in that compared to the control group, caregivers of children with chronic illness in the experimental group reported higher levels of distress on a posttest. Furthermore, the authors indicated that more than half of their study participants that were originally recruited chose not to participate in the study

because they were too busy and/or distressed to set aside time to write in journals. By contrast, the result of the current study is inconsistent with the growing body of literature demonstrating the psychological benefits of journal writing (e.g., Alpers et al., 2005; Barry & Singer, 2001; Pennebaker & Francis, 1996; Smyth, 1998).

The lack of intervention effects in the present study may be accounted for by several explanations, some of which are culturally related. Children of 80% of the participants received early intervention services during the course of the study. Receiving home-based special education and related services, and carrying out caretaking responsibilities for their children may keep these mothers from making time to write in a journal even for 20-minutes per day. This experience was similar to that reported by Schwartz and Drotar (2004). Being under pressure to complete the journal writing task may have caused additional distress for mothers in the experimental group in this present study. Clearly the perceived pressure of a journal writing intervention for individuals with busy schedules may not produce positive, immediate results, even if it may bring out benefits in the long run.

The guiding questions of the journal writing instructions used in this study may also have influenced the study results. The descriptions of factual experiences and negative emotions occurred as a pattern in the returned journal notebooks. Little evidence was found that the participants underwent an in-depth cognitive, reflective process and there seemed to be little effort spent on writing answers to all seven questions provided in the instructions. According to Pennebaker and Beall (1986), journal writing is most beneficial when individuals focus on facts and emotions while also facilitating cognitive processing. Ullrich and Lutgendorf (2002) reported a similar finding that individuals who wrote both emotional and cognitive aspects of traumatic events during disclosure demonstrated less physical illness and greater positive growth than those who wrote only emotional aspects. Thus, future research may consider modifying journal writing instructions to a way where participants can balance fact and emotional aspects, and cognitive processing of the stressful, traumatic experience to help them make sense of the experience and increase their understanding and acceptance of the experience.

The amount of intervention time may also need to be extended for real effects to occur, given the complexity of these processes. Special attention must also be paid to mothers with high levels of depression considering that Korean-Americans tend to underutilize mental health services and present a high risk for early termination of treatment (Bernstein et al., 2008).

Participants' ability to articulate their feelings and thoughts in writing may be another crucial element of the success of journal writing intervention. Barry and Singer (2001) found that a journal writing intervention reduced the psychological distress of European-American mothers of NICU infants. One difference between Barry and Singer's study and this study is whether or not the participants were able to express their thoughts and feelings in writing. Unlike Barry and Singer's study (2001), the Korean-American mothers in this study had

difficulty articulating their feelings and thoughts in writing. For example, many participants expressed to the author their wish to answer the questions verbally or in a short question-answer format, rather than in an essay format. Except for a few, the returned notebooks were relatively short in length and the narrative lacked substance.

One explanation for this difficulty in expressing may be that the majority of the participants were first generation Korean-American immigrants and received their education in their home country. Although emphasis in contemporary Korean education may have shifted, anecdotal evidence indicates that writing essays was not part of formal education. As a result, the participants may have difficulty with a journaling task. Nevertheless, a small number of the participants including those who were educated in the U.S. appeared to enjoy writing their journals and benefited from such writing. Thus, future research should consider that journaling might be an effective intervention for some mothers who are able to express their stressful experiences in writing. Future research should also consider the use of an audio-recorder, instead of requesting a written journal. Pennebaker and Francis (1996) found no difference in benefits between writing and talking about a traumatic and stressful event into an audio-recorder.

Although it may be less cost effective, having professionals or veteran parents having undergone a similar experience engage in dialogues with parents on the phone (for the same amount time that would be required for a journal writing intervention) may be another effective strategy in decreasing levels of maternal distress associated with childhood disability. One of the negative experiences that mothers of children with disabilities often express is social isolation (Paterson, 2003). Mothers may be able to better deal with their child related distress in frequent dialogues with professional coaches or veteran parents who have knowledge, skills, and experience in early intervention or special education. This may be done in conjunction with the journal writing intervention.

Limitations of the Study

Care must be taken regarding generalization of these findings because the relatively small sample size restricts generalization of results from statistics and some of the quantitative analyses. One reason for the small sample size was the combination of the relatively high attrition rate and difficulty recruiting study participants. Future research should use larger participant groups as well as individuals who are fluent writers in order to obtain a more comprehensive understanding of a journal writing intervention's effects on parents of children with special needs. Moreover, closer examination needs to be given to determining the "culturally sensitive" aspects of this type of intervention given that some of the culture-specific advantages expected from this intervention (e.g., time schedule, personal experience) showed a reverse effect. In particular, the restrictive personal (isolated)

nature of the task may have proven inconsistent with the need for social connectedness of this population. Overall, this exploratory study has heuristic value for future research in the area of culturally sensitive interventions for parents of children with disabilities.

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Successful Collaboration: Four Essential Traits of Effective Special Education Specialists

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Abstract

Successful inclusion is directly related to collaboration success between the special education specialist and the general classroom teacher. The role of the special educator has undergone steady change ever since students with exceptionalities were intentionally included in regular classrooms. This role now requires effective collaborative skills. There are four essential traits special educators need to develop if they are to successfully collaborate. They are thoughtful of self-understanding; knowledgeable of policies and best teaching practices; compassionate in attitude; and have well developed leadership qualities. These four traits are explained in relation to special education specialists. Practitioners are guided to identify their own areas of strength and need through an exercise in reflective practice.

The role of the special educator has undergone steady change ever since students with exceptionalities were intentionally included in regular classrooms. The purpose of this paper is to explore and improve upon the collaborative relationship between the special educator and the classroom teacher. Hutchinson (2006) writes that inclusion is the policies and values that society holds towards people with disabilities with the intention to allow their unhindered participation in education and society. In schools, inclusion manifests most obviously with the inclusion of students with disabilities within the average school classroom rather than in a separate, specialized classroom. The principles of inclusion have increasingly taken root and are mandated in many developed countries. Because students with special educational needs are increasingly being placed in general education classrooms, collaboration between the general classroom teachers and the special education specialist teacher has become critically important and is the most common method for planning for the success of students with exceptionalities in inclusive settings.

The need for improved collaborative skills between professionals has motivated researchers and educational thinkers to develop frameworks for collaboration and specific courses of study (Karasoff, 1999; Wiggins & Damore, 2006). Henning and Mitchell (2002) found collaborative training in pre-service teachers effective but still in the developmental stages. It is recognized that special education specialists need to find clarification of the required repertoire of skills, personal qualities, and the abilities necessary for effective collaboration. In this paper, traits that promote effective collaboration have been identified and organized into four areas. Effective collaborators in special education are: thoughtful; knowledgeable; compassionate, and leaders.

A reflective special educator can examine their own professional strengths and discover how their weaknesses and

personal attributes affect these four main areas of collaboration abilities. Through personal inquiry, they learn relevant areas for collaborative self-improvement. Consequently, the special educator will experience an increase in student learning and the professional growth necessary to enhance their own teaching career satisfaction.

Purpose of Collaboration

“Collaboration . . . means two or more people create an outcome for a student that no one of them could have created alone” (Ferguson, Ralph, & Katul, 1996, p. 34). This definition gets to the essence of what collaboration is—that working together we can achieve more than if we worked separately. Different boards, districts and educational institutions will achieve collaboration between their general educators and special educators in as many ways as there are people to collaborate. However, to be considered true collaboration, the participants must actively connect with each other on an emotional level and with mutual equity (Burbank & Kauchak, 2003).

A study of nineteen special education specialists, who were unattached to a specialized classroom, revealed sixteen variations in the titles given to their role (Ferguson et al., 1996). While these professionals may have different job titles, the study also found that the special educators had, in common, more than forty duties that they were expected to perform. While the depth and concentration of specific duties varied from person to person, of special importance was the common need to work collaboratively with general classroom teachers. Ripley (1997) writes, “the purpose of collaboration is to combine expertise” (p. 5). If a special educator recognizes the limits of his/her own imagination, resources, or stamina, it should indicate a natural necessity to get supportive assistance. The shift in professional roles and sheer complexity of inclusive special education, make collaboration the best tool

for solving problems that promote student learning. Although Ferguson et al., (1996) warned about the impossibility of being all things to all people, teachers have a responsibility to strive for excellence. Excellent collaboration can be accomplished by building upon and improving four essential collaborative traits.

Four Essential Traits

“Successful special educators are masters of collaboration” (Fisher, Frey & Thousand, 2003, p. 46). A look at the writing on successful collaboration between education specialists and various stakeholders in a student’s education reveal four areas of personal traits. Successful collaborators are thoughtful. They reflect on experiences, find their own strengths and areas of need, and ultimately act to improve their practice. They hold specialized knowledge about procedural policies and curriculum frameworks. They know about the nature of learning, have access to resources, and have a well-developed sense of students’ strengths and needs. Compassionate persons are required for effective collaboration. Successful collaborators are sincere in their sense of caring for students. The largest area of personal expertise is that in the realm of leadership and its many complexes and permutations. Successful collaboration requires high abilities in each of these four areas. An examination of each of these traits will reveal, for the special education specialist, critical components for self-improvement.

Thoughtfulness

An essential trait of successful collaborators is thoughtfulness. Thoughtful specialists engage in self-understanding and authentic reflection. Critical reflection is something mature teachers do more frequently than their younger counterparts (Karasoff, 1999). Being thoughtful includes thinking critically about roles and relationships. Thoughtfulness is necessary for meaningful reflection and ethics accountability. Imel (1992) states that it is necessary for teachers to look at themselves critically if any improvement in teaching is to occur. One needs to understand their personal strengths and areas of need; specialists need to know their limits so that they can push beyond them.

Because special education specialists are uniquely positioned to promote collaboration, their self-evaluations and personal assessments for growth are all the more important. Reflective practice is a form of professional development. Reflection is enhanced when it is shared honestly with trusting colleagues (Ferraro, 2000). Also, training choices and professional development planning will be well guided by first conducting thoughtful self-assessment. A powerful action plan is preceded by this type of meta-cognitive reflection. For example, through honest reflection a specialist may discover they do not keep student information in an efficient way. They therefore create a plan to address this need. They may read a

book to learn a new organization plan or talk with a respected colleague. After trying this newly learned method for a time, the specialist can consider whether this new data management technique suits them or whether they need to try a different method. It takes thoughtful reflection to continually change areas of weakness into areas of strength.

A set of ethical standards and standards of practice for the teaching profession can serve as a touchstone to measure the thoughtfulness required for collaborative success. The Ontario College of Teachers (2006) provides such a set. In Ontario, the reflecting teacher is mindful of moral thinking and ethical practices such as trust, integrity, respect, and care—communal traits for collaborative success.

In order to make purposeful planning choices, special education specialists need to use reason and logic in their decision making process. Collaborative problem solving and decision-making skills must focus on reasoned responses that solve short-term and long-term problems. For example, if a meeting was organized to discuss a student who has been demonstrating disruptive behavior, it would be necessary to gather behavior information from a variety of sources and differing settings so that premature decisions are avoided. Different teachers and parents will have had different encounters and experiences that naturally lead to varying perspectives and understandings of the student. There are many factors that affect behavior such as their environment, method of instruction, success and failures in life, social experiences, parenting abilities, personality conflicts, and behavior interventions in the past. By examining the history and other varied perspectives through collaboration, a working, logical plan will result rather than a rash and harmful decision.

Effective collaborators are receptive; they aim to understand the points of view and expectations of general classroom teachers (Purcell & Leppien, 1998). There is a natural tendency among education specialists to play the role of an expert instead of a partner (Pugach & Johnson, 1989). This paradigm causes true collaboration to be diminished. The thoughtful skill of understanding one another’s perspective takes continual effort. Effective collaborators exercise empathic skills to get into the mind of special education partners. Thoughtful special education specialists give respect to their collaborative partners and continually aim to understand the various types of personalities that make up educational teams. They respect the differences and values of their team and practice sincere listening first. They try to understand the meaning of the message without judgment. For example, when working with a general classroom teacher who is somewhat averse to inclusion, it is good to first listen to what the teacher’s problems are. Instead of launching into the need for inclusion in a theoretical way, time needs to be invested, by the specialist, into understanding and empathizing with the struggling regular classroom teacher. Are they a new teacher without experience? Are they an older teacher who doesn’t want to change? Are they enthusiastic but burnt out? Teachers want to do the best things for students so instead of

recommending stock solutions or presuming to know the answers, specialist need to take time to listen and fully understand the problem of the teacher. Understanding will give the special education collaborators the best information on how to proceed and thoughtfully advise for the appropriate problem and solutions.

Specialists will discover that by thoughtfully acknowledging their collaborative traits and reflecting on the advice of others (e.g., administrator, specialists, and other professionals) for personal improvement, collaborative efforts will be equitable and more enjoyable.

Knowledgeable

Frequently, it is the knowledge that special education specialists have that makes them a valued team member. Their specialized knowledge of procedures, curriculum, ways of learning, and current research makes collaboration with specialists valuable. This knowledge is gained through study, interests, and years of teaching experience. Pugach and Johnson (1989) state that it is not the title held that is important but, rather, that a team members value is in “the contributions each can make” (p. 233). Special education specialists should be aware of relevant legal responsibilities and special education law. They must have comprehensive understanding of district policies, plans, and procedures in special education if they are going to collaborate effectively with administrators, teachers, educational assistants, and other personnel.

While it may seem impossible to know the complete curriculum for every area of study, a familiarity and working knowledge of various curricula will complement the collaborative process (Purcell & Leppien, 1998). Specialist educators should strive to add to their knowledge by steadily learning and becoming comfortable with relevant curricula. One way to accomplish this is for the specialist to attend department subject group meetings. After every session of this type, one’s knowledge of the subject content and curriculum will be increased. In addition, one can provide, within this setting, expertise in differentiation for the current units of inquiry and study if appropriate. Attending curriculum meetings has the added advantage of building relationships with colleagues that will prove valuable in future student-centered, collaborative meetings. This will take a curiosity and a willingness to learn curricula and pedagogy outside of the specialist’s normal areas of study. Through the reflective process, the special education specialist will discover knowledge gaps, accept their own needs and take action to reduce or fill the gap with necessary knowledge. Over time, a more complete knowledge will be gained of the whole school curriculum.

A thorough knowledge of a student’s learning profile is necessary for good planning (French & Chopra, 2006). Specialists should be able to gather comprehensive information on a student’s strengths and needs from diagnostic reports and other formal and informal assessment data. The

specialist is in a position to request new assessments from other professionals. Acquiring knowledge through reading all of an individual student’s past records including, for example, the Individual Education Plans (IEP), which can provide the specialist collaborator with a relatively complete picture of successful and unsuccessful educational interventions. The special education specialist has training and experience to make sense of these varied sources and ultimately powerfully add to student planning discussions. Their knowledge guides them to informed conclusions based on authentic data assessments. With complete knowledge, the proper interpretations are discovered and meaningful learning profiles with substantial IEPs are subsequently developed collaboratively and monitored.

The most important knowledge a successful collaborator can hold is an understanding of best teaching practices. Special education specialists should have training and experience in a wide array of differing student exceptionalities. They must have the knowledge of appropriate pedagogies for each. Knowing how to adapt and differentiate the many curricula is essential for effective collaboration. Hutchinson’s (2006) acronymic strategy, ADAPT, can be used for adapting regular curriculum for exceptional students: *A* means *account* for student’s strengths and needs; *D* means *consider* the *demands* of the classroom; *A* means *adapt* for mismatches between student needs and the classroom; *P* means *perspectives* and consequences—consider the best practices; and *T* means *teach* and assess the match. Specialists should have resources for such adaptive consideration, be knowledgeable with differentiated instruction, and be willing to model adaptive teaching (Adelman & Taylor, 1998).

Knowledge is acquired through frequent professional development. Successful collaborators develop their body of knowledge through professional readings of current educational issues and trends found in books, journals, and magazines. They attend workshops and conferences on special education theory and practice. They seek objective appraisal from supervisors and participate on faculty committees. They become knowledgeable about educational concerns and creative options for teaching students with special educational needs at a local and the broader scale.

The principles of action research can be employed collaboratively as a form of professional development. Meaningful collaboration uses communicative problem solving and can be done in the context of discovery (Burbank & Kauchak, 2003; Pugach & Johnson, 1989). For example, when searching for an effective strategy to assist a student with delayed reading skills, collaborators can conduct a formal reading assessment on several students before beginning a new intervention. Collaborators could then apply a new reading technique and discover its effectiveness after a reassessment. Because the research was done collaboratively, the teacher’s understanding of the new technique is more likely to be retained. It can then be applied to a wider body of students if it was successful.

A special education specialist works to improve his/her collaborative skills by creating an information network. This network includes the inter-agency personnel, the school staff and parents. This knowledge network connects the collaborator to appropriate problem-solving resources and solutions. Also, in developing a professional resource bank, specialists are encouraged to share their resources and commit to collecting new, relevant reference items to achieve collaboration excellence (Purcell & Leppien, 1998). Knowledge of the relevant issues, teaching strategies, and answers available to a wide variety of problems make special education collaborative efforts informed and meaningful.

Compassionate

The importance of attitude cannot be understated. For successful inclusion to occur, the positive attitudes of service and the commitment to assisting students is as important as using appropriate information and resources (Elhoweris & Alsheikh, 2006; Henning & Mitchell, 2002; Stanovich & Jordan, 2002; Wilkins & Nietfeld, 2004). Successful inclusion depends on effective collaboration between the general classroom teacher and specialists. The special educator—in his/her capacity of teacher, consultant, and coordinator—must be sincere in adopting a caring, custodial attitude towards students and their learning needs. The successful collaborator respects the team members' viewpoints and differences but uses the common ground of compassion and care to guide all collective planning attempts.

One way to promote caring is to simulate disabilities. With recreations, such as wearing blindfolds to simulate blindness, or saying the alphabet backwards to simulate information processing delays, the intention behind recreations is to help the collaborators develop a sense of the student's areas of need and the implications of the disability. It is intended that simulations would allow participants develop an appreciation of the effort required or to better see the barriers to achieving success. Bergstahler and Doe (2004) caution simulation designers against using these recreations flippantly. They encourage deeper thinking and reflection to complement well designed disability simulations. Their advice encourages participants to develop simulations that inform on a range of implications including feelings and the promotion of positive attitudes.

An added dimension to exercising compassion is to have the perception to recognize negative attitudes in others. One must be able to intelligently persuade and tactfully educate those persons or procedures that interfere with successful collaboration. An increase in positive attitudes held by all stakeholders will benefit the exceptional student and the other students in an inclusive classroom (Santoli, Sachs, Romey, & McClurg, 2008). When confronted with a negative attitude or oppositional collaborator, the successful collaborator seeks to understand the reason for adversity before attempting persuasion. Support among teachers will be weak for the overzealous inclusion specialist. Rather, a negotiated approach

with the possibility of compromise and aiming to create a supportive partnership will be more successful for student learning than professional antagonism and forcing inclusion onto confrontational collaborators that reject inclusive principles.

The special education specialist's purpose is to dedicate themselves to assisting the planning and program delivery of educational services to students with exceptionalities and other students of unusual concern. Effective collaborators find proactive ways to help while being sensitive to the emotional needs of the students and their families. They use empathic listening skills with an authentic desire to help. Collaborative success hinges on this philosophy of positive attitudes and sincere commitment to service.

Leadership

Developing sophisticated leadership skills should be a prime goal for the special education specialist aiming for collaborative excellence. Superior communication and organizational skills need to augment courageous executive abilities that guide collaborative decision making.

Communication skills. Purcell and Leppien (1998) state that in collaborative teams "the assumptions of each party need to be understood" (p. 172). Purcell and Leppien suggest that "we can listen; be keenly observant; be patient; provide modeling or offer to co-teach, if necessary; avoid being judgmental; use praise and encouragement; and acknowledge the schedules and pressures of the classroom teacher" (p. 179).

It is counterproductive for a specialist to force his/her personal ideas and agenda during a collaborative meeting. There must be natural consensus; this takes interpersonal skills. A collaborative team has a range of personalities with valuable skills and understandings that, when considered, will make meaningful outcomes. For example, an experienced educational assistant may be well versed in Applied Behavior Analysis techniques for teaching students with autism but may be unfamiliar with the more recently developed SCERTS model. The Applied Behavior Analysis techniques focus on operant conditioning to teach communication and behavior skills while the SCERTS model aims to more holistic, family centered approach to teaching needed skills to students with autism spectrum disorders (Prizant, Weatherby, Rubin, & Laurant, 2003). This same person could be resistant to fully change their technique but with quality communication skills, a compromise or negotiated trial of the new techniques could be achieved. By making the investment in developing and practicing positive communication skills, special educators model excellent teaching and build team trust for the purpose of increasing student services.

Despite technological advances and well-intentioned written notes, "face-to-face communications in regularly scheduled meetings are absolutely necessary" (French & Chopra, 2006, p. 236). The personal contact between caring stakeholders is more immediate than a written message that can be put off for later convenience or avoided until urgent.

During moments of personal contact, relationships are strengthened and messages are clarified.

In face-to-face collaborative meetings, special education specialists have repeated opportunities to advocate for inclusive practices. Special educators need to develop and communicate a thoughtful philosophy of inclusive special education and deliver that philosophy in-person. Instead of writing an electronic mail message outlining a change in strategy, specialists should physically meet with the persons involved in implementing the change. Special education beliefs are better articulated and given more consideration when delivered in-person.

Effective communication engagements are mutually beneficial conversations between partners rather than between specialist and generalist. Effective collaboration between the specialist and his/her team, in addition to being regular, needs to engage all stakeholders (i.e., student, parents, teaching staff, paraprofessionals, administration, external service providers and other persons who charge it is to provide care to exceptional students).

Chains of communication should be established and important information needs to be shared appropriately. One important strategy is to have teachers report their student concerns to the special education specialist instead of using up staff meeting time to air their concern or sending out a mass mailing regarding one student. Instead, the specialist should be able to discretely gather information and follow-up on any concerns during a student services team meeting and beyond.

Organization. Special education specialists must work smarter. The most frequent reason cited by teachers as a being barrier to collaboration is time - not enough of it (Ripley, 1997; Santoli, Sachs, Romey, & McClurg, 2008). As busy as one may be, making time to plan is essential for well meaning inclusion to be successful. Chance meetings in the hallway or drop-by, informal consultations make collaboration shoddy and educational plans weaker than if scheduled meetings are arranged purposefully. Collaborative meetings encourage accountability and develop meaningful actions.

Working smarter involves considerable organizational skills. Effective collaborators know how precious their own time is and recognize that the same is true for other professionals. They appreciate the value of time and do not waste it. This takes an elevated degree of planning and superior data management skills. Special educators cannot afford to waste time bumbling through their documents during a collaborative session. One organizational method is to have a separate file for each student in one's care. Within the file, one could include anecdotes, observation records, summaries of assessments, and the most recent IEP. The modern specialist will transfer his/her files to a digital format for the ultimate in easing of transportation issues.

Teams. The contemporary research is consistent it its advocacy for using teams for navigating the complexity of special education delivery systems. Collaborative teams make sense in an age of diminishing resources (Adelman & Taylor, 1998; French & Chopra, 2006; Karasoff, 1999; Wiggins &

Damore, 2006). One special educator leader has the motto, "We think as a team. We make decisions as a team and we all implement as a team" (French & Chopra, 2006, p. 232).

Effective special education specialists collaborate with a team mentality. Well developed communication skills promote teamwork and feed the group processes necessary for effective collaboration. Solutions to problems that are approached collaboratively will have lasting effect. Acting as a detached consultant or non-invested expert creates an atmosphere of isolation and discourages participation.

The main purposes of collaboration have already been addressed but another reason for arranging collaborative teams is for the efficient collection and management of special education resources (Adelman & Talor, 1998). By combining resources, expedience is gained and access to information services is improved. Teams are useful for reducing the common stresses of teaching students with learning differences because one can share experiences and appreciate that they are not alone with student difficulties. Adelman & Taylor (1998) find that resource management teams also have the benefit of eliminating disputes arising from overlapping duties and roles. The building of trust is crucial to team success and so is the sense of commitment each member has to the collaborative endeavor—feeling ultimately responsible for the success of the student (French & Chopra, 2006).

Executive Leadership. Teams need leaders. For all this collaborating to be successful the specialist educator must be willing to act as an executive leader. The special education specialist is a logical choice for leading the collaborative team. Being knowledgeable, they will have processed the big picture that steers the collaboration to logical ends. Also, the specialist should have the network with necessary persons involved and have access to methods of accounting for progress. Training and experience have given them the necessary skills to supervise paraprofessionals and communicate student needs with teachers and communicative staff needs with administrators. The specialist is experienced in gathering assessment data and determining authentic learning profiles of exceptional students. His/her holistic perspective makes them a natural first choice.

While giving direction, effective special education specialists are ever mindful of the modern principles of balanced, person-centered leadership (Adelman & Taylor, 1998; French & Chopra, 2006). Effective leadership from specialists requires the validating of others' thoughts. By this, they empower teachers and paraprofessionals to make decisions, act, and deliver powerful special education services in inclusive classrooms.

Collaborative leaders expect results from team members and ensure that collaborators are routinely held accountable for successes and evaluated for areas for improvement. For every collaborative meeting, the leader needs to record items for action, the date for completion, and who is responsible. This summary, or meeting minutes, should be passed to each team member preferably no later than one day following a collaborative meeting.

The effective team leader needs to practice follow-through on ideas. They appraise the results of programs, interventions, and team members' actions for making necessary changes. Meticulous organization of documentation and relevant data must support decisions to alter personnel activities and programming choices (Adelman & Taylor, 1998). Specialists also reflect on their own role and make themselves accountable to their collaborative teams. A supportive team will be open about their needs and other things that are not working as planned. A specialist can make others comfortable and establish trusting if they set an example in acknowledging his/her own weakness or areas of necessary growth.

Courageous. Team leaders need courage. Superior special education specialists possess beliefs based on a sound philosophy of inclusion and special education services. They have appropriate long-term vision and are focused on student learning goals. His/her beliefs are tactfully and clearly communicated to the collaborative group.

Special education advocacy requires bravery because inclusion frequently involves a complex of perspectives and foresight in its implementation (Wiggins & Damore, 2006). The complexities of planning will sometimes conflict with others' attitudes and methods. Collaboration success requires specialists who advocate the best practices and constructs for learning.

There are natural differences in approaches to problem solving and barriers to successful collaboration. Some such barriers are culture differences, education, and philosophical beliefs. (Karasoff, 1999). Overcoming these differences is not always part of one's professional teacher training program so specialists must reflect and train themselves and their collaborative teams. Otherwise, teams will get hung up on differences instead of bravely attempting compromise.

It takes courage to look at one's weaknesses and make professional personal changes. If one has been trained in a teacher-centered pedagogy, it will take extra work to solve problems that require a student-centered pedagogy. Reflection upon one's teaching methods, in this case, would be required for student success and professional satisfaction.

Effective collaborators need to be willing to exercise independence and be willing to try new approaches and untried, creative ideas. Trying the untried takes courage and communicating fresh ideas to the collaborative team is necessary for the specialist aiming for new interventions and effective program planning.

Recommendations and Conclusion

Including students in the general classroom effectively requires multi-professional coordination. Scheduled collaboration between the special educational specialist and general classroom teacher is an effective way to create positive outcomes for exceptional students.

The effective special education specialist is encouraged to begin his/her self-improvement plan with thoughtful self-reflection. A rubric focused on the four collaborative traits is

provided in Figure 1 for this purpose. After reflecting on their collaborative traits, specialists should focus future professional development activities to directly target those areas most in need. Within the rubric, Level 3 indicates the most developed collaborative trait. Professional development in special education issues and collaborative practice should be taken at every opportunity.

As collaborative team leaders, it is necessary for special education specialists to evaluate their philosophy of special education and personal beliefs about inclusion. The updating and development of philosophies is important because they are essential guides to teaching practices that will have an immediate impact on their collaborative groups. This self-evaluative process should be done at least annually and be kept as a central part of a teacher's professional reflective portfolio for supervisor's feedback and support.

Deepening of knowledge will be a successful teacher's duty throughout his/her career. Specialists are challenged to expand their repertoire of skills. Pushing into new territories of understanding will complement their experiences thus increasing their collaborative value.

Developing traits of compassion is usually accomplished by spending supportive time with students with exceptionalities. Familiarity with the successes and challenges of students and their parents is necessary to develop the personal connections to become caring. Observing special education teachers and spending time discussing the amount of caring will typically enable the specialist to see the student holistically. A common attitude of stewardship and caring will be valuable for bringing together the members of the collaborative team.

Leadership skills can be learned and improved through study and practice. Most institutions expect special education specialists to perform leadership type duties such as team leading and staff development. Fortunately, materials on educational leadership are easily accessible. Leadership skills, because of their importance, should be a priority. Finding a leadership mentor or an experienced special educational specialist in a collaborative role will provide one with valuable experience and increase one's comfort and familiarity with the need collaborative leadership.

Thoughtfulness, knowledge, compassion, and leadership are the four traits for which special education specialists must endeavor to improve if their collaborative work is to be effective. A reflective educator will review his/her practice and find his/her own strengths and needs and accordingly improve them. Though this process, collaboration will be successful at serving the needs of exceptional students.

Traits	Level 1	Level 2	Level 3
Thoughtfulness – Thinking critically about collaborative practice, the specialist:			
Reflective (strengths & needs)	<input type="checkbox"/> occasionally reflects on practice <input type="checkbox"/> considers improving	<input type="checkbox"/> annually reflects <input type="checkbox"/> makes goals for improvement	<input type="checkbox"/> annually reflects and seeks supervisor's appraisal <input type="checkbox"/> makes a complete action plan with specific goals
Ethical (trust, respect, integrity & care)	<input type="checkbox"/> relies on personal convictions <input type="checkbox"/> is primarily guided by intuition	<input type="checkbox"/> is familiar with some professional ethical standards <input type="checkbox"/> has some standards that inform practice	<input type="checkbox"/> has developed a complete understanding of ethical standards <input type="checkbox"/> is guided by professional standards
Logical (reasoned decisions & acts)	<input type="checkbox"/> responds to situations without seeking varied sources <input type="checkbox"/> bases action on his/her own ideas	<input type="checkbox"/> gathers some information then acts <input type="checkbox"/> bases action on anecdotal data	<input type="checkbox"/> seeks complete information from a variety of sources before acting <input type="checkbox"/> bases action on research
Receptive (points of view)	<input type="checkbox"/> prefers to plan alone	<input type="checkbox"/> considers his/her point of view and those present at meetings	<input type="checkbox"/> considers all stakeholders' points of view even when absent <input type="checkbox"/> understands various perspectives

Knowledgeable – Aware of issues and trends in special education, the specialist:			
Procedural (law & policies)	<input type="checkbox"/> relies on others for legal and policy clarification	<input type="checkbox"/> is somewhat familiar with district policies	<input type="checkbox"/> has considerable awareness of law and district policies
Curricular	<input type="checkbox"/> is skilled in his/her own area of initial training	<input type="checkbox"/> understands some other areas	<input type="checkbox"/> understands most areas <input type="checkbox"/> is curious and seeks new subject experiences
Students (strengths & needs, practices)	<input type="checkbox"/> observes students	<input type="checkbox"/> reads student records and talks to parents <input type="checkbox"/> familiar with best practices for some exceptionalities	<input type="checkbox"/> develops comprehensive student learning profiles <input type="checkbox"/> completely understands best adaptive practices for most exceptionalities
Information (professional development [PD], resources network)	<input type="checkbox"/> has PD annually	<input type="checkbox"/> annually has PD in special education	<input type="checkbox"/> has regular, relevant PD <input type="checkbox"/> has an accessible resource bank <input type="checkbox"/> has information network

Traits	Level 1	Level 2	Level 3
Compassionate – In caring for students, the specialist:			
Attitude	<input type="checkbox"/> usually positive <input type="checkbox"/> avoids negative people	<input type="checkbox"/> is usually enthusiastic <input type="checkbox"/> ignores negativity	<input type="checkbox"/> always promotes positive modes of thought in others <input type="checkbox"/> uses position to actively dispel myths & negativity
Empathy	<input type="checkbox"/> feels sorry for students and parents	<input type="checkbox"/> considers student's feelings <input type="checkbox"/> recognizes differences	<input type="checkbox"/> sensitive to feelings and wishes of parents & students <input type="checkbox"/> respects differences

Leadership – In making collaboration happen, the specialist:			
Communication	<input type="checkbox"/> tells opinions <input type="checkbox"/> prefers written	<input type="checkbox"/> makes agreements <input type="checkbox"/> writes messages and checks in person	<input type="checkbox"/> respectfully builds team consensus <input type="checkbox"/> prefers face-to-face contact
Organization (information sharing)	<input type="checkbox"/> has some casual and some schedule meetings <input type="checkbox"/> keeps data	<input type="checkbox"/> usually has scheduled meetings <input type="checkbox"/> somewhat manages data	<input type="checkbox"/> schedules meetings and always considers time <input type="checkbox"/> manages data efficiently
Teamwork (collaborates)	<input type="checkbox"/> views self as an expert <input type="checkbox"/> shares all information except data about self-limits	<input type="checkbox"/> sees self as teammate <input type="checkbox"/> shares most information including self-limits	<input type="checkbox"/> leads by partnering with stakeholders <input type="checkbox"/> shares only necessary information freely
Executive (decision making)	<input type="checkbox"/> usually makes decisions <input type="checkbox"/> completes his/her own work	<input type="checkbox"/> makes some decisions but relies on consensus <input type="checkbox"/> records ideas and checks on others for follow-through	<input type="checkbox"/> values and empowers team to make decisions <input type="checkbox"/> follows through and makes others and themselves accountable
Courage (takes reasoned risks)	<input type="checkbox"/> has good inclusion and educational intentions <input type="checkbox"/> recognizes barriers to inclusion	<input type="checkbox"/> has a philosophy of education <input type="checkbox"/> recognizes complexity of inter-professional relations <input type="checkbox"/> works to promote inclusive practices <input type="checkbox"/> can work and act independently	<input type="checkbox"/> articulates philosophy of inclusion and education <input type="checkbox"/> handles the complexity of inter-professional and other relations effectively <input type="checkbox"/> creatively removes barriers to inclusion <input type="checkbox"/> can work independently and take responsibility

Figure 1. Self-assessment Rubric for Special Education Specialists Collaborative Traits

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Enhancing Inclusive Educational Practices within Secondary Schools in Brunei Darussalam

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Abstract

Inclusive education policies have been espoused by the Ministry of Education in Brunei Darussalam since the late 1990's. In this paper, the author examines the current state of inclusion in secondary schools throughout the country. Procedures, practices and processes which directly or indirectly impede the realization of national and international imperatives are highlighted. Best practices derived from the literature are recommended to address such challenges. These include a stronger focus upon: the dismantling of organizational barriers to inclusive education; measures to enhance related school and community attitudes; the use of Universal Design for Learning principles and practices; appropriate teacher education and support; collaborative teaching strategies and ongoing dialogue between relevant stakeholders. Modifications to the existing pre-vocational program are suggested, as well as the appointment of special education needs coordinators in all secondary schools.

Introduction

It would not be overly dramatic to suggest that inclusive education in Brunei Darussalam is at a crossroads; or perhaps, to use a more apt traffic metaphor, at a roundabout. Educators seeking a suitable route to enhance inclusion within secondary schools face difficult choices and challenges. Inclusive objectives remain ambiguous, diversions and barriers abound and few explicit guidelines are available to schools and teachers to help them determine how best to proceed.

The Current Context

Brunei Darussalam is a small country located on the island of Borneo in South East Asia. It is a member of the Commonwealth of Nations and an independent Malay Islamic Constitutional Monarchy. It has a total population of around 380,000, with approximately 70,000 students enrolled in government schools. A further 30,000 students attend private primary or secondary schools. Most citizens are bilingual (Malay and English), with English as the primary medium of instruction in schools from Primary 4 levels onwards.

It cannot be denied that much has been accomplished within the country over the past 15 years to enhance services and support for students considered to have special educational needs (SEN). More than 300 local teachers have acquired tertiary qualifications in the field at Certificate, Bachelor or Masters Degree levels. A majority of these teachers have completed their studies within the country, taking courses developed by the University of Brunei Darussalam (UBD), in collaboration with the Special Education Unit of the Ministry of Education. Many additional

government scholarships have been awarded to local citizens to study developments in the field abroad and obtain internationally recognized qualifications at overseas institutions. The expertise they have developed and the skills which they have acquired have generally been put to good use in schools upon their return.

Relevant Government policies have been established to facilitate further developments. All children in Brunei are now entitled to 12 years of free education in Government schools. Under the Compulsory Education Order of 2007, attendance during the first nine years is mandatory for children of school age. In March 2005, Brunei Darussalam became one of the most recent members of the United Nations Educational, Scientific and Cultural Organization (UNESCO). The government is committed to ensuring "Education for All" and the provision of "Inclusive Education" in accord with UNESCO policies.

At the 2nd National Seminar and Workshop on Special Education held in Brunei Darussalam in 2008, the Permanent Secretary (Core Education), Ministry of Education re-asserted this, stating:

Equality of opportunity and educational excellence are key goals for 21st Century education in Brunei Darussalam. The government's vision is to ensure all children have opportunities to realize their potential. To achieve this, policy makers, educators, and community members must regularly review and update their knowledge and adopt relevant practices that are in accord with inclusive educational principles. Let me confirm again today, that the Brunei Government is committed to promoting quality

education for all, as an appropriate means of “Nation Building” (*Apsah Hj Abdul Majid, 2009, p5*).

Detailed national reports are now submitted to UNESCO, outlining annual efforts and achievements in Brunei Darussalam related to the Education for All initiative. This enhances transparency and accountability and helps ensure that a register is kept of actions taken to realize related national and international goals.

Existing Challenges

Despite this, a daunting array of challenges still confronts policy makers, school staff and professionals working in the field of special education. The nature of inclusive education envisaged for the country remains elusive, especially at the secondary education level. Extensive additional human resources, facilities, technology, equipment and educational materials are required. There is a pressing need to expand training and continuing professional education for all stakeholders. Legal and ethical parameters within the field require clarification. The need for positive attitudinal and organizational change to enhance the implementation of inclusive practices is pervasive.

Many of these challenges mirror those faced in countries around the world (Kochhar, West & Taymans, 2000; Meijer, 2005; Szecsi & Giambo, 2007). Numerous studies suggest that classroom teachers do not consider themselves well prepared to teach students with increasingly diverse educational needs (Baker, 2005; Bradshaw & Mundia, 2006). Additional training and continuing professional education is generally considered essential (Florian & Rouse, 2001; Sharpe & Hawes, 2003). If schools are to maximize the extent to which they educate children with SEN in regular classes, in accord with inclusive principles, they require the facilities, technology, equipment, human resources and training provisions needed to do so effectively.

While most, if not all of these challenges may involve additional financial expenditure, there is a corresponding need for critical analysis concerning the nature and type of support required, to ensure it is in accord with best practice and national imperatives. Thorough consideration must also be given to epistemological and pedagogical aspects and the perspectives of all stakeholders.

Global Considerations

Before addressing challenges specific to the secondary education context within Brunei Darussalam, it would be appropriate to briefly examine existing international perspectives concerning the nature and intent of inclusive education.

As Slee (2001) contends, the notion of inclusion has garnered comprehensive international support, as a means to promote social justice, educational equity and social

cohesiveness. Whilst a small minority still express disparate views about educational opportunities for girls, it is now almost universally considered appropriate that all children have a right to formal education. The fact that more than 190 countries are signatories to UNESCO accords regarding the provision of Education for All, attests to this.

At the same time, as many writers in the field suggest, what is deemed to constitute inclusive education can vary widely from school to school, system to system and country to country (Hines, 2001; Worrell, 2008; Zaretsky, 2005). As Slee (2001) purports, some use the term to refer to unconditional access to regular classes, while others use it to refer to a sliding scale of partial participation in regular educational settings. This continuum is particularly problematic. The uncertainty involved hampers debate and research concerning the viability and effectiveness of inclusive education within and across national boundaries. It also affords nations, educational systems and schools an opportunity to assert that they have inclusive educational policies, while taking a minimalist approach toward the implementation of related practices.

UNESCO does provide some useful guidelines concerning the intent of inclusion. In booklets and accords promoted by this world body, the concept is framed within the wider context of education for all, rather than as a matter primarily applicable to students who have disabilities. It is suggested that inclusive educational systems require provisions to help recognize and combat discriminatory attitudes towards any group (UNESCO, 2005). The elimination of exclusionary school facilities, programs and practices is an essential aspect of this process. It may reasonably be argued that many countries, including Brunei Darussalam, have given insufficient practical emphasis to this facet of inclusion.

The implementation of inclusive education is acknowledged to be a complex process involving major organizational change to school systems and evolving provisions for diverse populations of students (UNESCO, 2005). Accordingly, it is important that it be considered a continuous or ongoing process. Simplistic evaluations of systems and schools to determine whether they are or are not inclusive are inappropriate and insufficient. As Villa, Thousand, Nevin and Liston (2005) indicate, the successful implementation of inclusive education involves short and long term strategic planning, as well as constant changes in curriculum content, teaching strategies and organizational structures.

Given that this is the case, it would seem acceptable for governments to claim they are implementing inclusive education if pertinent goals are clearly stated, political and financial commitments have been made to facilitate the realization of such goals, detailed strategic plans are guiding the process and there is evidence that such plans are being progressively implemented.

Unfortunately, such aspects are not always apparent. Meijer (2005) and Worrell (2008) cite examples which suggest that the effective implementation of inclusive

education often lags well behind associated policy in many European and American contexts. Other international examples are outlined by Mutepe, Mpfu and Chataika (2007) and Villa et al. (2003) in descriptions they provide of inclusive education in Zimbabwe and Vietnam respectively. As details in the following section of this paper indicate, Brunei Darussalam is no exception.

UNESCO guidelines also suggest that the physical presence and participation of students with disabilities in regular schools, classes and extra curricula activities should be considered a primary indicator of inclusive educational practice. Villa et al. (2005) concur and suggest that schools need to reflect a broad range of co-existing human conditions and dimensions in order to prepare students well for participation in the wider, complex, heterogeneous world.

As the Council for Exceptional Children (2006) proposes, this involves bringing support to the child rather than the reverse. It entails educating children with SEN in regular schools and classes to the maximum extent possible. Students with SEN include those with mild, moderate or severe intellectual, academic, genetic, sensory, physical, health, behavioral, social-emotional or communication difficulties. In inclusive schools, the proportion of such children enrolled would generally be expected to mirror their distribution amongst the general population. If smaller percentages are evident, exclusionary school features may be responsible. If the proportion of students with SEN is significantly higher than usual, segregated educational practices may be a feature of the school and the system involved.

Finally, UNESCO (2005) highlights the need to give particular consideration to groups which are at greatest risk of marginalization and exclusion. Students with SEN generally fall into this category. As Slee (2001) and Zaretsky (2005) suggest, existing sociological discourse tends to perpetuate their exclusion from regular schools. Sophisticated language and procedures are often used to generalize the categories and consequences of childhood and adolescent disorders, impairments and disabilities. Children's learning difficulties may be simplistically located in student pathologies or their intellectual and behavioral characteristics. Paramedical specialists such as psychologists, speech pathologists, occupational therapists and special educators are employed by many governments to assess and diagnose student problems and devise related "cures" and/or "interventions".

There is an assumption that these specialists will be able to assist school personnel devise appropriate ways to guide and manage differing student conditions, largely within existing organizational structures. Distinct special educational programs, practices and placements may be proposed for the students concerned, based upon the identification and validation of their disabilities. The paramedical model involved encourages schools to focus upon treatment of the child rather than upon social, organizational and environmental constructs which sustain the disadvantages and difficulties the child may experience.

Teachers and parents unfamiliar with the terminology or the conditions involved can often become anxious about the capacity of schools to include such children (Florian & Rouse 2001; Sharpe & Howes, 2003; Szecsi & Giambo, 2007). When insufficient human and material resources are available to assist classroom teachers in providing relevant educational activities for those who require extensive support, the problems are compounded. Marginalization and/or exclusion of such students from regular classes and school environments then becomes even more likely. Parents may seek alternative placements for the children concerned in external community facilities or programs that seem able to provide more assistance. Associations, facilities and programs abound at national and international levels to support those diagnosed as having dyslexia, autism, Down syndrome, attention deficit disorders and the like.

This is not meant to suggest that specialized support and activities are not worthwhile for such children. Rather it is meant to highlight the fact that these children routinely face exclusion from mainstream schools. As proponents of inclusion would argue, their absence from regular classes and schools may be considered disabling in itself for the children concerned, a denial of their equal educational rights and a social injustice.

The diminished cultural and political status of special education in many countries is reflected in the tolerance afforded by parents and educators to the separation of students with high support needs from mainstream classes and schools. If other "at-risk" groups were to be excluded from regular educational facilities and programs, on the basis of their particular characteristics (e.g., race, gender, ethnic background, religion or socio-economic status), vociferous and justifiable criticism might be expected from respective community advocates.

As UNESCO guidelines propose, to embrace inclusion, educators must give systematic, comprehensive consideration to the needs of groups which are most at risk of marginalization or exclusion. Students with SEN, particularly those with minor incidence disabilities and high support needs, figure prominently amongst groups who require such consideration. To ensure their inclusion, concerted action is required to identify and remove barriers which limit their participation in regular school activities.

Considerations within Brunei Darussalam

Community Attitudes

Within Brunei Darussalam, community support for those with special needs is widespread. Sufficient financial donations have been garnered from business organizations and general community members to enable the establishment and maintenance of a range of non-government organizations to support children of school age who have very high support needs. These include the Society for the Management of Autism Related Issues in Training, Education and Resources

(SMARTER), Learning Ladders (for children with autism) and Pusat Ehsan Al-Ameerah Al-Hajjah Maryam (for those with intellectual disabilities). Media coverage of special events for children with disabilities is extensive and community members and volunteers provide regular, on-going assistance at the facilities listed. However, the interest shown and support provided often reflects undertones of sympathy, care, charity, abnormality, separation and protection. There is little emphasis upon the implementation of inclusive educational approaches or equal educational rights for the children involved.

Parental demand has generally fuelled the growth of such organizations. Families typically seek placement for their children at such centers if government schools have difficulty meeting their specific needs and cannot match the facilities and services provided. Although relying primarily upon charitable support, the community organizations listed offer individualized programs for the children and adolescents concerned, in separate, well resourced, but segregated facilities.

Secondary Education Provisions

Political, community and cultural perspectives are reflected to a large extent in current secondary school provisions for those with SEN. School facilities and organizational structures reflect a substantial degree of segregation for many students with high support needs. Since the late 1990's a pre-vocational program has been provided at selected government secondary schools. This program was initially devised to help address the needs of overage students who had moved to secondary level after repeating many years of their primary schooling. In recent years, the pre-vocational program has been used as an alternative placement for students who have intellectual disabilities, Down syndrome, autism or severe adaptive behavior problems.

While considerable effort is made to provide individualized education plans and relevant differentiated activities for these students, they are separated from mainstream students for most educational activities. All school members are generally aware that those involved in the pre-vocational program have very low academic ability and severe problems of one kind or another. Accordingly, it can be difficult to ensure that negative social stigma is not attached to membership of such classes. Their exclusion from regular classes, "home rooms" and "tutor groups" compounds such problems and can limit their social inclusion and acceptance by peers. As Graham and Slee (2008) report, "placement in special classes and units within mainstream schools can result in segregation just as profound in its effect upon children's social lives as enrolment in a special school" (p. 4).

In the country report presented by Brunei Darussalam at the International Conference on Education in Geneva 2008 there is little to indicate that changes are envisaged to enhance the inclusiveness of the pre-vocational program and to

maximize the participation of the students involved in regular secondary classes, subjects or extra curricula activities (UNESCO, 2008). This would seem necessary for the program to be aligned with existing national policy and the government's international commitments concerning inclusive education.

While additional human and material resources, training and specialist support may be required to realize such imperatives, the scope of the task would appear manageable, given the fact that only 224 students are involved (UNESCO, 2008). However, appropriate dialogue between relevant stakeholders and a combined commitment to the task will be essential to effect the changes involved.

Secondary students with visual, hearing or physical impairments, specific learning disabilities and medical conditions which impede academic progress face different but equally daunting disadvantages. Although they are generally included within mainstream programs in government or private schools, rather than the pre-vocational program, these students must cope as best possible in regular classes, with quite limited individualized support. In Brunei Darussalam, special education teachers in schools are described as Special Education Needs Assistance (SENA) teachers. While most SEN teachers in government primary schools are assigned full-time responsibility for students with special needs in their respective schools, equivalent arrangements are not generally provided at secondary level.

Many secondary teachers have obtained relevant university qualifications to work as SEN teachers over the past ten years, with direct Government sponsorship and support (Koay, 2008; Lim, Mak, & Koay, 2006). However, few have ultimately been assigned to positions as full-time special education needs coordinators (SENCOs) or SEN teachers in government secondary schools upon completion of their studies. Direct, ongoing assistance for students with special needs and consultative and collaborative support for their teachers has been limited accordingly.

The two aspects of secondary education described above have persisted for almost a decade and have thus become somewhat entrenched. Specific strategies and action plans are urgently required within both the government and private school sectors to address these matters, if the marginalization and exclusion involved is to be carefully dismantled and more inclusive educational practices are to be progressively incorporated.

Comparative Levels of Support

To date, in distributing human and material resources to support students with SEN in Brunei Darussalam, a disproportionate emphasis has been given to special education provisions at primary education level. At secondary level, the appointment of full time SEN teachers or SENCO's has been afforded lesser importance. While home room teachers help co-ordinate the pre-vocational program in each of the secondary schools involved, far less support is provided to

address the requirements of other students with SEN. It is uncertain whether this is because the scale of needs has not been adequately elucidated or because it has been afforded a low priority by school management and relevant government agencies.

Approximately 450 students in government schools follow individualized remedial education plans during their final year of primary schooling (Ministry of Education, 2008). These plans are specifically designed to address their learning difficulties and needs. SENA teachers in the respective primary schools help implement such plans. However, when these students move to secondary level, their remedial education plans lapse.

Most secondary schools do attempt to provide some remedial assistance for those experiencing academic difficulties. However, if the more comprehensive programs of support provided at primary levels for students with SEN are to be maintained at secondary level, an equivalent distribution of SENA teachers will be required. This would entail the appointment of at least one qualified SENA teacher in each of the 36 government secondary schools within Brunei Darussalam (Ministry of Education, 2009) to co-ordinate such support. Without the direct and consultative assistance which such teachers can provide, it might reasonably be expected that the academic achievement levels of the students involved would diminish accordingly, along with their self esteem and personal development.

Students with sensory impairments (hearing, visual and physical), medical conditions, speech/communication problems, attention/concentration difficulties and other special needs also move from primary to secondary each year. It might conservatively be estimated that at least 5% of the total student population experience such difficulties (i.e. approximately 50 students per secondary school). These students also require the ongoing support which SENA teachers can provide, to maximize their progress and realize their potential.

The more extensive support currently provided at primary level in Brunei Darussalam may be considered a commendable means to address student difficulties before they become entrenched. However, as Deschler (2006) contends, as compelling as the case may be for early intervention to support those with SEN, it should not be made at the expense of addressing equally problematic and unique sets of problems for adolescents.

The Private Education Sector

In the non-government sector, fewer than 10% of schools currently employ qualified special education teaching staff to support students with SEN. Private schools generally favor the admission of students with higher intellectual and/or academic achievement levels and many tend to minimize the enrolment of students with SEN. While approximately one third of all primary and secondary students attend private educational establishments, government schools carry much greater

responsibility for the education of those with SEN. In non-government schools, additional fees are sometimes applicable if students are deemed to require significantly higher levels of individual support than their age peers (Jerudong International School, 2009; International School Brunei, 2009). Equal educational rights and social justice in Brunei Darussalam are diminished accordingly.

Community Organizations

It is evident that considerable effort has been expended by existing community organizations to ensure that appropriate facilities, equipment, resources and staff are available to support students with high support needs within Brunei Darussalam. In this regard, what has been achieved must be considered exemplary. It is also evident, however, that these establishments entail a high degree of separation and exclusion from the mainstream educational process. They reflect more traditional, segregated approaches to the provision of educational opportunities for students with special needs, rather than the inclusive education models now being promoted at national and international levels.

Careful consideration would seem warranted to ensure that the respective merits of traditional and inclusive models are recognized and that these are adequately encompassed in future plans for secondary education. As Zaretsky (2005) contends, multiple perspectives must be incorporated when addressing special education issues, to derive more refined understanding of existing dilemmas and develop sophisticated solutions. While it would not be appropriate to perpetuate the exclusion and marginalization of children who have significantly greater or differentiated educational needs by actively encouraging the development and use of segregated facilities, neither is it appropriate to simply include such children in mainstream school settings, without making adequate provision for their needs.

Looking Ahead: Strategies and Suggestions

Significant efforts have been made since the mid nineties to introduce more inclusive educational approaches in Brunei Darussalam. However, new strategies and commitments are required to ensure the continuation of this process in the realm of secondary education, where current programs, provisions and practices appear less in keeping with inclusive principles. Mainstream educational provisions for students with high support needs also require close re-examination. As the growth of more exclusive segregated community facilities attests, existing inclusive provisions in government schools would seem insufficient to address the needs of such children.

Model Inclusive Schools

The establishment of a small number of model inclusive schools is a recent Ministry of Education initiative which shows promise. Additional human and resource materials are

being provided to the government schools involved to help them develop inclusive practices and demonstrate the effectiveness of related educational approaches. It is critical that the schools concerned succeed in this endeavor if this type of approach is to be accepted on a system wide scale. It is also important that the initiative reflects best practice in the field albeit in accord with a realistic time frame. Given existing shortages of local personnel with related training and qualifications, it may be necessary to engage international teaching, professional and ancillary staff temporarily in these schools to ensure inherent inclusive goals are achievable.

It would also seem important to ensure that the schools involved do not become defacto special schools attracting disproportionate numbers of students with SEN because of the additional human and material resources available. Should this occur, it will negate the validity of the scheme as a means to establish the viability of inclusive educational approaches. Existing criteria for the admission of such students would suggest that planners have acceded to the temptation to include students with high support needs who live outside the immediate boundaries of the schools involved. Unless it is clearly specified that such measures are a temporary facet of ongoing strategic plans, there is a strong likelihood that the establishment of these schools will be viewed more as an expedient avenue for the re-location and segregation of students with high support needs than a genuine attempt to demonstrate the effectiveness of inclusive educational approaches.

Universal Design for Learning

Within secondary schools, there is a pressing need to incorporate procedures and processes which will help cater for the diverse population of students with SEN. Detailed planning will be required to help maximize the participation and achievements of such students in regular classes and school environments. As Villa et al. (2005) suggest, teachers can address their diverse learning needs effectively by utilizing Universal Design for Learning (UDL) and differentiated curricula. UDL entails the design of instructional materials and activities to facilitate the achievement of learning goals by individuals who have wide differences in their abilities “to see, hear, speak, move, read, write, understand English, attend, organize, engage, and remember” (Orkwis, 2003, p. 1).

The usability of classrooms & learning content can be expanded through multiple means of engagement, presentation, expression and support (Bremer, Clapper, Hitchcock, Hall, & Kachgal, 2002). Relevant options include more extensive use of audio, video, text, Braille, signing, captions, speaking, e-learning, assistive technology, drawing and augmentative communication strategies such as the picture exchange communication system (PECS). The employment of full time special education needs coordinators in all secondary schools would greatly enhance the

coordination and implementation of such support within Brunei Darussalam.

Collaboration and Administrative Support

Extensive use of collaboration is a key feature of successful inclusive programs in secondary schools (Meijer, 2005; Worrell, 2008). Associated elements include the use of multiple instructional agents and support in classes, co-operative and team teaching approaches, flexible timetabling and block scheduling (Villa et al., 2005).

School principals play a key role in promoting collaboration and the use of inclusive practices (Zaretsky, 2005; Cawalti, 1994). To craft inclusive learning communities they must help build consensus about the worth of related practices, re-organize and expand associated resources, implement measures to ensure staff can develop the knowledge and skills required, create relevant incentives for all involved and promote public awareness concerning associated school policies, procedures and initiatives (Villa et al., 2005).

Efforts to expand the use of inclusive practices at secondary level within Brunei Darussalam are unlikely to be successful without the support of school principals. It is essential that relevant means be devised to garner and build this support.

Community Agencies

Close collaboration will also be needed between representatives from the Ministry of Education and community agencies mentioned previously in this paper, to enhance national provisions for secondary students with high support needs. Some sharing of resources and delineation of complementary school and external agency responsibilities may help resolve existing dilemmas.

Centers established by such community organizations provide viable examples of the facilities, staff & resource levels needed to deliver relevant, individualized programs for such children. While comparable provisions remain unavailable in secondary schools, it is likely that parents will continue to seek alternative placements for their children. Additional special education teachers, professionals and ancillary staff will be needed to ensure pertinent aspects are adequately addressed within schools.

Legislation

Many countries have enacted legislation to enshrine the rights of children with SEN to equal educational opportunities and relevant support (e.g., IDEA (1997) in the USA, OPSI (2001) in the U.K. and DDA (1992) in Australia). Such legislation generally addresses a wide range of associated matters including funding provisions, assessment and placement procedures, the development and implementation of individualized education plans, the provision of relevant

assistive technology, the accessibility of facilities and curricula, human and material support, agency responsibility, parental rights and many other aspects. To enhance the implementation of existing national and international imperatives concerning education for all and inclusive education in Brunei Darussalam it would be timely to consider the establishment of an equivalent legal framework, which reflects the nation's aspirations and values and clarifies the rights and obligations of all concerned.

Other Aspects

To inform future planning at secondary level, it would also be timely for the Government of Brunei Darussalam to review the specific nature & intent of existing inclusive education policies. Clear objectives and strategic plans might be framed regarding model inclusive schools, the secondary pre-vocational program, the secondary SENA teacher/SENCO program, continuing professional education for teachers and other stakeholders, the roles and responsibilities of relevant community organizations and private schools and the promotion of public awareness & parental involvement.

Conclusion

Inclusion embodies principles which have and deserve widespread support. The form which education systems must take in order to adequately reflect these principles requires ongoing clarification and commitment. As Zaretsky (2005) and Slee (2001) indicate, multi-theoretical perspectives are needed to derive sophisticated understandings of the issues involved. It is important that disability is recognized as "a relational concept embedded within a sociological discourse" (Slee, 2001, p. 176). Educational systems, practices and placements which are based primarily upon the identification and validation of disabilities tend to perpetuate exclusion and social injustice. The use of community agencies and special schools, units or programs as a primary means to cater for the needs of those who require high levels of support can compound such problems.

At the same time, it is undeniable that specialized facilities, equipment, professional practices and extra support can be of undoubted benefit to students who have significant academic difficulties, sensory impairments, speech/communication, intellectual, academic, behavioral, social-emotional, physical or health related learning difficulties. Close co-operation and collaboration between relevant government and community agencies will be required to delineate complementary approaches and responsibilities to ensure the rights of all students are respected and addressed.

If inclusive educational approaches within Brunei Darussalam are to be enhanced more coordinated and comprehensive efforts will be required to redesign educational environments and organizational structures so that future facilities, programs and practices address the diverse learning needs of all students.

This will entail the provision of additional human and material resources, related legislation, measures to promote public awareness and support and associated professional development and training opportunities for those directly involved. While it is sometimes assumed that school communities and nations will need to bear significant additional costs to achieve such ends, longer term perspectives suggest that the savings which may be derived will more than offset such costs. Our schools must ensure that students with special educational needs do not remain disabled, dependent citizens for life. With suitable opportunities to maximize their potential, there is a far greater chance that they will become socially active, productive, contributing community members and social welfare costs will be minimized. As Lindqvist (as cited in UNESCO, 2005) wrote some 15 years ago, "it is not our education systems that have a right to certain types of children. Therefore, it is the school system of a country that must be adjusted to meet the needs of all children" (p. 13).

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Exploring Teachers' Perspectives: Qualms and Possibilities for Inclusive Classes in Pakistan

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Abstract

Inclusion is a developmental process rather abrupt action of implementing a system. It is concerned with the type of modifications and adaptations required in the schools to accommodate all students with diverse educational needs. In inclusive schools, all children irrespective of their abilities learn together and enjoy the same rights and facilities within the same class. This is contrary to a segregated system of education where students with disabilities learn separately from their counterparts. It seems that inclusion appears at once an ideal to be reached and a potential means of minimizing discrimination in education. This study identifies teachers' needs in ordinary schools and explores their perceptions about inclusive classes in Pakistan. Results of this study indicate that although most of the teachers are willing to teach inclusive classes with adequate training and resources, they have qualms and are not sure to what extent their teaching will be effective for all. In this regard they identify some of the barriers they might face in the school system. While discussing possibilities about inclusive classes some of them suggested a few strategies to orchestrate and harmonize the classes with students with diverse educational needs.

Introduction

Inclusion is a developmental process of addressing diverse needs and increasing participation of students with special needs in schools, culture and communities. It differs from integration where students with special needs are considered visitors instead of full time students as their counterparts in general education schools. Perception about the existence of deficits within and outside a child distinguishes integration and inclusion respectively. According to Armstrong (2008) inclusion situates the barriers to participation within the school or college while integration focuses on the perceived deficits in the child as creating barriers to participation. Unfolding barriers within institutions and societies consequently creates awareness to minimize exclusion. Booth, Nes & Stromstad (2004) inclusion is concerned with development of school and teacher education institutions.

Plaisance (2006) defines inclusion as a struggle for the effective application of rights. It is also a continuous process, which requires permanent creativity in terms of developing innovative practice in daily social life. D'Alessio (2006) conceives of inclusive education as a broad theme that goes beyond the educational domain to encompass political,

societal, ethical and economic values and actions and identifies integration as a series of structural, organizational and curricular responses to meet diversity in regular schools related to the educational domain and, for the most part, in relation to students with disabilities. UNESCO (2006) defines inclusive education as an approach that looks into how to transform education systems and other learning environments in order to respond to the diversity of learners, while it defines integration as how some learners can be integrated in mainstream education. Hence, quality education is seen as education that is inclusive as it aims at the full participation of all learners.

Inclusion is not a process of abrupt implementation of a system; it is rather concerned with the type of developments required in the schools to accommodate all students with diverse educational needs. It is impossible to transform ordinary schools into inclusive ones without identifying the needs of teachers currently teaching in those schools. Agbenyega (2007) stated that teachers do not have the required knowledge and expertise to teach students with disabilities who are included in their general classes. Meijer (2005) explained that teachers' practices depend on their

training, experience, beliefs and attitudes as well as on the situation in the classroom and in schools and are affected by external organizational factors such as political and financial ones as well as local and regional resources.

UNICEF (2003) pointed out that no serious movement has so far surfaced for inclusive education in Pakistan. At the federal level, the implications for inclusive education have been recognized in principle, but have not been fully incorporated in practice. General education schools accommodate children with physical disabilities, those who can listen with the help of hearing aids, and who have low vision. Segregated schools also exist for children with physical, mental, hearing and visual impairments.

Inclusion: A Wide-Ranging Debate

In between pros and cons discussion, inclusion oscillates on the continuum of various issues. For more effective inclusive practices, these issues should be resolved. Clough (1998) analysing the principles underpinning inclusion explained that the history of special education has been a history of inclusion and a history of exclusion. There are many pressures within the general education system that encourage the use of special educational procedures to exclude troublesome children and special schools as a means of managing those children once excluded. The following section discusses some of the issues involved in inclusion.

Special Education Schools: Means to Manage Excluded Children

Basically, special schools in Pakistan were established to accommodate those children who had not been accepted or welcomed in general schools. Supporters of segregation while keeping its historical perspective in view, may argue is it being felt the need to include again these children in those schools, once which became themselves a source of segregation. In stating what is special about special education Clough (1998) writes that the history of special education has at one and the same time been both a history of inclusion and a history of exclusion. As general education schools could not accommodate children with disabilities because these students did not meet their standards, special education institutions were established to accommodate them.

Inclusive Education Development on a Global Level

UNESCO (2006) stated that the movement of inclusion, within the rights framework, started in 1948 with the universal declaration of human rights which ensured the right to free and compulsory elementary education for all children. In 1966, the universal declaration of human rights ensured the right to free and compulsory education for all children. Rieser (2008) refers to the article 13 of the UN International Covenant on Economic, Social and Cultural Rights of 1966 which stresses that primary education should be compulsory

and free to all. In 1989, the UN convention on the rights of the child established the right for all children to receive education without discrimination on any grounds. The world declaration on education for all (the Jomtien Declaration) that was agreed in 1990 emphasized Education for All (EFA). The rule 6 of UN standard rules on the equalisation of opportunities for persons with disabilities (1993) affirms the equal rights to education of all children, youth and adults with disabilities and also states that education should be provided in 'an integrated school setting' and in the 'general school setting'. The Salamanca declaration and framework for action on special needs education stated that '... schools should accommodate all children regardless of their physical, intellectual, social, emotional, linguistic or other conditions'. Rieser (2008) refers World Education Forum 2000: Framework for Action, Dakar (EFA Goals and Millennium Development Goals) which ensures that all children have access to and complete free primary education by 2015. EFA Flagship on the Right to Education for Persons with Disabilities (2001) links Education for All with the Salamanca Framework for Action and the need to include children with disabilities and other marginalised children. The article 24 of UN Convention on the Rights of People with Disabilities (2006) promotes the right of persons with disabilities to inclusive education. The Lisbon Declaration (2007) related to experiences of young people with disabilities also supports inclusive education. According to this document there should be the availability of necessary support, resources and trained teachers.

The Current State of Inclusion in Pakistan

Pakistan has progressed enough to recognize inclusion of students as a rights issue but more needs to be done to translate the rights into school practices. The first government endorsement of education of children with special needs can be traced back to a report of the National Commission on Education in 1959. The commission recommended that teachers of children with disabilities should be trained in their specialized field. The 1972 Education Policy allocated funds for providing special education services for the first time in Pakistan. The Decade of the Disabled (1983–92) raised an awareness of disabilities in Pakistan. During this period, the country made remarkable progress both in the area of special education, teacher preparation and the range of services provided to children with disabilities (Sultana, 1993). In Pakistan, children with disabilities are taught in segregated schools. The only exceptions to such segregation are indigenous systems such as the system of religious education called Deeni Madaris (UNICEF, 2003). In this charity-based system some type of inclusion appeared to exist whereby pupils with disabilities, particularly children with visual impairment, are included.

The National Policy for Rehabilitation of the Disabled was formulated in 1986 to stress integrated education. In the National Policy for Education and Rehabilitation of the

disabled (1988), the word 'education' was added in the title as opposed to previous policies. The National Policy of Special Education was promulgated in 1998 for various special education institutions. The Government of Pakistan in the National Policy for Persons with Disabilities, stated that any government-level initiative for inclusive education must start with a special education section in the Ministry of Education (Ministry of social welfare and special education, Pakistan, 2002). According to this document, a special education section would be the most appropriate place for the design and implementation of a policy on inclusive education. Further development at policy level has taken place as it appeared in the national report on the development of education in 2008 in which the Ministry of Education emphasized that the inclusive development program needs to be embedded within the general education system with the support of professionals trained in special education. At present two separate ministries exist in the country for general and special education system. The Ministry of Education controls general schools in the country but a separate ministry has been established to meet the needs of children with special needs. No coordination exists between the two ministries to promote inclusive education in general schools.

The goal of equal opportunities cannot be achieved only through a limited number of special education centers established by the Directorate General of Special Education (DGSE), the Ministry of Social Welfare and Special Education, Provincial Governments, and NGOs. According to UNICEF (2003), globally, it is estimated that 70% of children with disabilities attend general schools provided the environment is accessible and the institution is willing to accommodate them. Further, UNICEF (2003) elaborated that in Pakistan, it has been acknowledged by the Government that the disability prevalence rate based on the 1998 census is low and does not represent the true number of people with disabilities in the country and moreover the Government also estimated based on the 6th five year plan that people with disabilities comprise approximately 4 to 6% of the total population. In the National Report on the Development of Education (2008), Ministry of Education has ultimately reached to the conclusion that it is not required to establish special education centers for all challenged children since educational needs to over 90 percent such children can only be met in general schools.

The teachers' education programmes for general school teachers and special education teachers are totally separate in Pakistan. The education departments in universities and education colleges prepare teachers for general schools while special education departments of universities prepare special education teachers. There exists no collaboration among these departments to facilitate communication and train teachers for inclusive practices. The purpose of this study was to explore the perceptions of teachers teaching at schools about inclusive classes in Pakistan. The purpose of this study was to answer the following research questions: Are teachers of general classes ready to welcome children with special educational

needs? How do teachers feel about including students with disabilities in general classes? What do teachers think about their competencies to teach such classes? What are teachers' views about the possibilities of inclusive classes? What kind of barriers do teachers perceive and what strategies do they suggest to improve their schools for inclusive classes?

Method

Participants and Sampling

A total of sixty-three teachers working in general education schools of Lahore city which is in the Punjab region of Pakistan were purposively sampled to participate in this study. However, Out of the sixty-three teachers, fifty-four questionnaires were sent back. Thirty three of the teachers were from eleven private schools and 21 teachers were from seven public schools. A total of ten teachers who didn't fill out the questionnaire were selected from ten different schools for interviews.

Survey Instrument

The questionnaire developed for this study consisted of four parts. The first part consisted of basic demographic information such as qualification, age, teaching experience etc. The second part consisted of questions related to professional competencies of teachers, class and time management, class stress, provision of resources, curriculum appropriateness, and general awareness about children with disabilities. The third part consisted of questions that asked about teacher's acceptance of children with disabilities in general classes and willingness to participate in training concerning inclusive education. The final part asked questions related to barriers in inclusive practices. All questions were rated on a five-point Likert scale. If the respondent was strongly agree with the statement then the response was coded as 5, for agree as 4, for unknown as 3, for disagree as 2, and if the respondent was strongly disagree then the response was coded as 1. To validate the questionnaire, expert opinion was sought from four professors of education. For the purpose of the pilot testing of the instrument, the researchers visited the schools and administered/distributed the questionnaires among 31 teachers to determine its reliability. A reliability analysis was undertaken with the help of Statistical Package for the Social Sciences (SPSS version 15.0). The value of alpha coefficient (coefficient of consistency of items of the questionnaire) was found to be 0.865, which indicate that the instrument has high internal consistency.

Procedure

After the reliability analysis was undertaken the questionnaire was distributed to a total of sixty-three teachers. To examine the perceptions of teachers, qualitative and quantitative approaches were used. A questionnaire was administered to complement the data collected via the open-

ended interviews. A total of ten teachers were purposively selected for the interviews. The choice was based on teachers' willingness for interview. The teachers selected for filling out the questionnaire and for interviews were from different schools. Among them six were teaching in private schools the other four were teaching in public schools. All were teaching at primary and elementary levels. These teachers were chosen because there is a probability of presence of children with disabilities at these grade levels. These teachers were interviewed at their schools/institutions. Ample opportunity was provided for each teacher to express his/her views about inclusive classes. The researchers conducted these interviews in Urdu language and recorded the interviews. The researchers later transcribed and translated these interviews into English. The open-ended questions related to their observations, experiences, possibilities and problems of inclusive classes, resources availability, and knowledge and training to teach such classes were asked and are given below:

1. How do you feel if students with disabilities are present in your class along with other students without disabilities?
2. How do you solve the problems you face while teaching this class?
3. How do you explore the opportunities to enrich your experience during teaching?
4. Do you think you have enough knowledge and skills to teach them along with their peers in the same class?
5. If you don't have enough knowledge and skills then in what areas you need to improve to teach such type of class?
6. What do you say about your current level of professional expertise with regards to inclusive education?
7. What changes you would like to see to make your class more inclusive?
8. What types of support school's administrators and parents are offering and what you desire?
9. Advocates claim that inclusion has positive academic and social effect for students with exceptionalities. In your view what would some of the possible positive effects be and what would some of the possible negative effects be?

Data analysis

From questionnaire data, frequencies against all demographic variables and percentage of teachers' responses against questions were calculated using SPSS version 15. For example, Table 1 shows how teachers responded to the item "I support students with disabilities to be included in the general class."

Data from the interviews was transcribed and translated into English. Intensive reading of each interview was made and categories were identified for similar responses. Seven different categories were identified which include: (a)

individual attention, time and class management, (b) awareness, competency development and curriculum, (c) provision of resources, (d) class strength and teacher stress, (e) support from administrators, parents and special teachers, (f) acceptance of disabilities and uncertainty about consequences, and (g) cooperation, friendship and stigmatization (labelling).

Results

Almost 67% of the teachers were between 30 to 50 years of age. Nearly 83% of them had a Masters degree. All of the teachers had a B.Ed. or an M.Ed. degree. About 47% of them were designated either as senior school teacher (SST) or subject specialist (SS). Their teaching experience varied from 11 to 25 years. Most of them were teaching at secondary level and the total number of students in their classes varied from 30 to 70. Although no correlation test was done to confirm this, generally teachers' responses showed that it was difficult for them to teach a large class especially when the class was inclusive.

Table 1

Teachers Responses to the Item "I support students with disabilities to be included in the general class."

Choice	Frequency	Percentage
Strongly agree	12	22
Agree	22	41
Do not know	0	0
Disagree	15	28
Strongly disagree	5	9

Teachers' Reluctance and Inclination to Teach Inclusive Classes

About 63% of the teachers agreed to teach inclusive classes but in some situations, contrary to their readiness, they did not seem to be confident in their willingness. The percentage analysis illustrates that almost 63% teachers agreed that they could give equal attention to all students including students with disabilities in their classes but 50% were confident that they could teach effectively while the rest of them had qualms about teaching these inclusive classes. Mostly teachers refused to accept that ordinary classrooms are not suitable for inclusive classes. About 62% of the teachers think that specially decorated and well equipped classrooms are required to teach children with disabilities along with their counterparts. Nearly 63% of teachers expressed their dissatisfaction towards the present curriculum because it does

not help to organize activities to teach all students in inclusive classes.

Half of the teachers disagreed with the idea that the presence of students with disabilities in ordinary classes does not affect other students. As far as including students with disabilities is concerned, almost 77% of the teachers had no objection if the disabilities were mild. About 64% of teachers favored the inclusion of students with behavior and emotional disorders, mild visual and hearing impairments, and physical disabilities. On the other hand, nearly 76% of teachers did not support the idea of inclusive classes with students with severe and profound disabilities.

Need for Training and Support About 70.4% teachers strongly agreed to attend training/refresher courses on the subject if offered. Almost 79.7% also strongly agreed that teaching inclusive classes can further be possible for us with support from a special education teacher. Nearly 69.3% of teachers favored cooperation among their colleagues to find out solutions to problems in inclusive classes. Moreover, about 80% of the teachers lamented poor attitudes of general schools teachers towards including students with disabilities in their classes. They appreciated mixing of students with different abilities/disabilities for their socialization among their counterparts.

Need for Human and Material Resources

Nearly 93% teachers responded to a question positively that in ordinary schools no specialized support teacher is available who can guide regular class teachers to teach in inclusive class. Nearly 80% of the teachers took into account other factors like inappropriate infrastructure of schools and large class sizes which further limit the possibilities of inclusive classes in Pakistan.

The analysis of teachers' interviews and interpretation of their perceptions reflect how they perceived inclusive classes, whether they thought inclusion was possible or not, barriers in inclusive classes/schools and their qualms about inclusive classes.

Individual Attention, Time and Class Management

For 60% of the teachers it is possible to teach inclusive classes. For example, a teacher was of the opinion that if every teacher starts to give attention to children with disabilities in his/her class then positive outcomes might be expected. Similarly, another teacher expressed his views as "... you have to change the structure and you have to manage the time in the class". On the contrary, almost 40% of the teachers were equally afraid of this practice. One science teacher having 14 years teaching experience in private schools explained "it is not easy to teach these students... they need individual attention...for example, teaching visually impaired children, and it is difficult to give them the concept of colours". About 70% of the teachers did not consider children with mild disabilities as a problem. They thought that they could be

managed in small classes. A public school teacher expressed their point in these words: "...due to large class sizes it is not possible for us to give individual attention....., if students have minor visual problems or hearing problems or some type of physical disabilities, they are like other normal students...what we do is we just change their places according to their needs."

Awareness, Competency Development and Curriculum

The word "inclusion" was new to 90% of the teachers. Nearly 70% of them also emphasized awareness and considered its importance for the acceptance of children with disabilities. One of them uttered: "... for inclusion, the main thing is the teacher's awareness." Another teacher expressed their views regarding class diversity and lesson plan as: "... if there is diversity in the class then there should be diversity in the lesson plan ...". They were also of the opinion that awareness may modify people's behaviour. A senior school geography teacher gave their argument as "... people and teachers' attitude make them feel handicapped..., sometimes these students exploit their disability in the class..., many teachers while checking their homework give them much relaxation..., they don't even bother about the output of these children because they have made false assumptions about them and resultantly these children get advantages which is in fact a disadvantage for them..., teachers give them much relaxation and this makes them feel, we are special and due to this they not only do not do their homework but also they develop negative feelings about themselves..., actually on a religious basis, you know, we have a system to give sympathy to such students... and it is dangerous for them... so, in this way, we exploit our religion and consequently we turn them into beggars instead of making them productive."

On the other hand, another teacher showed their concerns regarding inclusive classes stating "the teacher has also problems due to children with disabilities in class because in their presence, it is difficult to satisfy others." Giving arguments in favour of inclusion, one teacher shared their opinion: "... this will be a good opportunity not only for teachers to teach in classes of diverse cultures but also for students who would learn from each other..., we were not trained to teach in inclusive settings." Mostly teachers were afraid of not having enough competencies to teach this class. They also complained about teacher trainers. For example, a teacher explained: "... I need more knowledge and competence to teach inclusive classes but this is only possible if competent teacher trainers are available."

Provision of Resources

During interviews about 90% of the teachers pointed out that basic facilities were not available in public schools. A public school teacher, sharing their school's situation regarding provision of resources when they have a student with physical disabilities in their class, complained "we need

physical facilities because there remains problem in the school due to non availability of wheel chairs etc.”

Class Strength and Teacher Stress

Analysis of interviews also shows that teachers of public schools were under stress due to large classes. One of the teachers opposed inclusive classes because this would increase their burden. The teacher elaborated: “... if you have experience of teaching in school especially in a public school then you can understand our problem arising from large classes.” A teacher having three years teaching experience explained: “... yes, if there is a large number of disabled students in the class then there would be problems and I don’t know how I would solve this problem in a public school where sometime students exceed hundred in one class.”

Support from Administrators, Parents and Special Teachers

Almost all the teachers agreed that without administrators, parents and special teacher support, it is not possible to teach inclusive classes. A teacher who was teaching in school as well as in university expressed their views as “I will need to consult special teachers to teach blind students in such classes”. Another teacher explained that “... to make classes inclusive depends on the administrator because he has the power to offer admission to a child with special needs in his school”. Some teachers made administrators responsible for not accepting students with disabilities in their classes. One of them reiterated that “...he (administrator) thinks that my teachers cannot teach these students..., they (administrators) should have some flexibility in their approach, which is lacking in our school’s Rector”. Another teacher also expressed similar views as: “... in the private sector, to make one school inclusive, it totally depends on the owner of the school and they don’t have much awareness in this regard..., if they (administrator) think they cannot earn much money from inclusive school, they will never do it, at any cost”. One teacher emphasized parent-teacher meetings in this respect: “in public schools, there is no parent-teacher meeting. Another teacher explained that the parents of normal children don’t accept children with disabilities along with their own children in the same class. A similar comment was given by another teacher as: “Parents of children with disabilities, perhaps, will support this idea but I don’t think parents of children without disabilities will do anything about it, rather they will raise objections to it”.

Acceptance of Disabilities and Uncertainty about Consequences

As far as acceptance of disability is concerned almost all teachers were willing to welcome students with disabilities in their classes. However, they had qualms about the consequences. For example, one principal/teacher running

their own private school said “... teachers of my school were hesitant when there was a student with disabilities in our school..., I personally like the idea but I don’t know how it will work..., there may be many problems/difficulties..., I am not confident.” Another teacher was confused about inclusive class and stated “I don’t know how teachers will teach, if many disabled students in the class are present..., we want to include these children but I don’t know how it will be possible.

Cooperation, Friendship and Stigmatization (Labelling)

All the teachers emphasized cooperation among students both with and without disabilities in inclusive classes. Although they had fears about the consequences they suggested some strategies for inclusive classes. One of them who had vast experience teaching in private school shared their experiences as: “...you can also develop peer-cooperation and manage the class..., I think, if teachers divide their work and get students involved, they can do it..., you can make groups of different students of different abilities and get them involved in mutual cooperation..., I personally observed in my class that children belonging to different cultures enhance their learning from their mutual interaction.” A language teacher who also had enough experience of teaching in private schools recalled their experience with students with disabilities as: “... I remember the days when I taught a child with learning disability and upon successfully completing every step during her course of study she was more confident and other children also took positive image of her that she is not behind us in learning and she can also do the things that we can do.” Teachers also pointed out that many children without disabilities stigmatized (labelled) children with disabilities. A school principal/teacher explained “...when she (a child without arms) was admitted and joined the class other students became alert and conscious... they also started to call her with bad names.” A public school senior science teacher suggested that teachers could stop this labelling simply by giving moral lessons in class. One teacher favored inclusion starting from early childhood. They suggested, “... I think inclusive classes should be started as early as possible..., this is a good time for children to learn together.”

Discussion

The survey indicated that the teachers in Pakistan were ready to teach inclusive classes with students with mild disabilities. They accepted children with mild disabilities in their classes but not children with severe disabilities. The teachers responded shows that there exists mixed opinion regarding teachers’ anxiety and stress. They had fear about time management in inclusive classes. They needed orientation to special education. Teachers did not think that enough resources were available in their schools except some private school teachers. General education schools should be improved to accommodate children with disabilities. In

general education schools no support from special education, who can guide the general education teachers, was available. This shows that inclusive classes can be possible if support teachers are provided in schools. Lack of awareness about inclusion among teachers was evident and this can be compensated through training and orientation to special needs children.

The analysis of teachers' interviews and contextual interpretation of their perceptions reflected how teachers perceived inclusive classes, whether they thought inclusion was possible or not and what barriers they might face to teach inclusive classes. Almost similar perceptions of teachers have been found in interviews as the survey indicated. Teachers were reluctant to include children with disabilities. While stating their reservations about the possibility of inclusive classes, they explained that teaching time for inclusive classes must be enhanced otherwise children with special needs would not be properly attended. Inclusion seems to be utopia where general education teachers do not have awareness, they are not oriented to children with special education needs, and they don't have inclusive curriculum which helps them to organize activities for inclusive classes. Inclusion in overcrowded general education classes and without at least minimum required resources only increases stress for the teachers. Lacking support either from administrators or from community reduces the possibility of inclusion especially in public schools as the survey as well as the interviews showed. Good coordination among teachers, between teachers and administrator and between teachers and parents can be helpful to inclusive practices in general education schools. Specifically, the collegial support including support from special education teacher to share and discuss the everyday class problems can never be ignored. Developing friendly environments in general education schools in Pakistan might build friendships among children with and without disabilities. Telling stories illustrating moral lesson may free children with disabilities from stigma in classes, schools or in society at large.

It is clear that large class sizes are a problem for teachers to include students with disabilities. So class sizes should be reduced and shortage of teachers in public schools should be addressed. Teachers in Pakistan do not have proper training or orientation to special education needs. Proper course content should be included in teachers' training courses to give awareness about special education to general education teachers. Resource scarcity is another major problem for inclusive classes. Researchers also found that general education teachers perceive that probably there would be many students with disabilities in general classes hence they are afraid to include them. The opposite may be true because according to UNICEF (2003), the Government of Pakistan based on the 6th five year plan, has estimated that people with disabilities comprise approximately 4 to 6% of the total population. There will probably be two or three children with disabilities per class. These misconceptions prevailing among general education schools' teachers demand for proper

orientation to inclusion. Special education teachers can be appointed in general education school for inclusive support.

There is no particular difference found in the perceptions between general education public and private schools' teachers about inclusive classes. In Pakistan, public schools are poorly equipped as far as buildings and other resources are concerned. In public schools, huge classes and shortage of teachers are the problem. Private schools are categorized into two. Some of the private schools are well equipped but very expensive while most of them are poorly managed street schools and no proper buildings and well trained staff are available. Teachers of all these schools are not confident enough to teach inclusive classes yet they did not make any excuse that they cannot teach these classes.

This research had some limitations. The researchers did not have enough resources and time to conduct large scale surveys and interviews. The research was only conducted in one of the big cities of Pakistan so it may not represent the perception of the rest of teachers in general education public and private schools in other cities and provinces. The study also may not represent the perceptions of teachers in rural schools. It may be possible that teachers in rural general education schools have different perceptions about inclusive classes.

Conclusion

Managing children with various levels of disabilities within one class seems to be difficult for class teachers of general education schools. Inclusive classes challenge teachers to muddle through and cope with it.

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The Effects of Classroom Management on the Behaviors of Students with Disabilities in Inclusive Classrooms in Turkey

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Abstract

The purpose of this study was to determine whether the behaviors of the students with disabilities placed in general education classrooms differed according to the classroom management level of the teachers. The classroom management strategies of the 44 teachers were assessed by using The Proactive Classroom Management Observation Form. The behaviors of the student with disabilities were assessed by trained observers during instruction. The Code for Instructional Structure and Student Academic Response-Mainstreaming Version was used to collect data related to the students' behaviors. The results indicated that the students with disabilities displayed a few number of behaviors during instruction and the teachers had serious difficulties managing inclusive classrooms. The academic behaviors of the students with disabilities from the highest, the medium and the lowest level of classroom management groups were not found to be significantly different. On the other hand, the problem behaviors and the task management behaviors of the students with disabilities were found to have been affected by the classroom management of the teachers. The findings of the study were discussed in terms of the literature related to inclusive classroom management and the problems of mainstreaming system in Turkey.

Introduction

Classroom management can be defined as teacher's actions providing and sustaining an effective learning environment so that all the children can achieve as much as possible (Brophy, 2006). In other words, classroom management includes all teacher behaviors that increase the academic engagement of all children and prevent any inappropriate and disruptive behaviors. The results of research focused on classroom management revealed that effective classroom management increased academic achievement and decreased problem behaviors of students (Brophy & Evertson, 1976; Good & Brophy, 2003; Good & Grouws, 1977; Kounin, 1970; Evertson, Emmer, Sanford & Clements, 1983; Marzano & Marzano, 2003; Westwood, 1993). Unfortunately, there is still a limited number of studies focusing on strategies and techniques used in inclusive classroom (Soodak & Mc Charty, 2006). Most of the current studies indicate that teachers have difficulties in terms of managing inclusive classrooms (Emmer & Stough, 2001). According to Mc Intosh (1994) teachers were able to make some adaptations for children with special needs during whole class teaching. However, they seemed to lack the background and training required to instruct students with disabilities effectively, and they were not able to differentiate the instruction according to characteristics of the

students (Baker & Zigmond, 1995). Teachers are mostly concerned about the problem behaviors of their students during instruction (Blanton, Blanton & Cross; 1993; Hanrahan, Goodman & Rapagna, 1990) and they do not know effective ways to manage these behaviors.

Even though several methodological limitations such as experimental control issues, validity and sampling issues affect research related to inclusive classroom management (Soodak & Mc Charty, 2006) several methods which could be effective on students' disruptive behaviors have been documented. A few researchers propose the instructional approach for managing the problem behaviors of students with disabilities. This approach emphasizes teaching appropriate behaviors instead of focusing on inappropriate behaviors (Carpenter & McKee-Higgins, 1996; Colvin, Kameenui & Sugai, 1993; Reitz, 1994). On a different note, Niles (2005) identified proactive management strategies such as adapting instruction according to the unique learning characteristics of individual students or giving feedback to students on their performance throughout the learning experience. Niles stated that these practices could be helpful in alleviating the fears felt by teachers who teach diverse classrooms.

Many strategies were recommended for the teachers based on the idea that teacher behaviors are related to student achievement (Englert, 1983; Sutherland & Oswald, 2008;

Sutherland, Lewis-Palmer, Stichter & Morgan, 2008; Westwood, 1993). It has been established that teachers who monitor student behaviors and teach correct responses by giving feedbacks are more effective teachers (Jones & Jones, 2001). Larivee (1986) stated that when general classroom teachers use time effectively and give positive feedback to all students, students with disabilities demonstrate a greater level of achievement. In contrast, when teachers waste time with transitions or when they have a low ability in using intervention programs for inappropriate behaviors, and when they criticize student responses, students with disabilities display the lowest academic achievement with a high degree of off-task behaviors or actions.

Wood (2002) identified differentiating the amount of time required to complete tasks, the duration of learning activities and the type of responses expected from students as important strategies for inclusive classrooms. Adjusting the pace of instruction and planning the instruction as well as taking into account the prerequisite skills of the students were given greater importance, while presentation skills were considered one of the factors causing inappropriate behaviors in classrooms (Murdick & Petch-Hogan, 1996). Rademacher, Schumaker and Deshler (1996) argued that if the quality and the level of difficulty of homework were adjusted according to the level of the students with mild disabilities, academic engagement would increase and therefore disruptive behaviors would decrease.

The other important factor in effective classroom management is the use of praises by teachers for students' appropriate behaviors. Teachers who reinforce appropriate behaviors of their students frequently experience less problems regarding classroom management (Jones & Jones, 2001). In addition to these strategies, classroom rules and procedures focused on positive behaviors decrease management difficulties in inclusive classrooms (Brophy, 1983). Determining and teaching the rules make the environment conducive for learning, and produce the largest gains to be obtained by the students (Simeonsen, Fairbanks, Briesch, Myers, & Sugai, 2008). Teaching in inclusive classroom may be frightening for some teachers, but as explained above, making proactive organization and modifications provide opportunities for all students, including students with disabilities, to be engaged and to demonstrate more appropriate behaviors during instruction. Effective classroom management must therefore, be considered one of the most important factors for successful inclusion.

Mainstreaming in Turkey

In Turkey the law mandating that children with disabilities should be placed in general classroom was accepted in 1983 and mainstreaming has been expanding throughout Turkey since then. The effectiveness of mainstreaming has been questioned in the light of the problems being encountered by the children, their parents and especially the teachers since 1990. Research investigating the opinions of teachers, parents

and principals of elementary schools indicate that teachers have difficulty teaching students with disabilities because of their limitations (Kargin, Acarlar, & Sucuođlu, 2005). Teachers reported that they had problems with planning instruction for heterogeneous classrooms and making adaptations according to the needs of the students. They also stated that they needed guidance and information on how to teach in mainstreamed classrooms. According to the teachers, children with disabilities who have limited academic skills negatively affect the learning environment of the classrooms and thus, the rest of students suffer (Kargin et al., 2005; Uysal, 2003).

In addition, the teachers who had children with mental retardation in their classrooms explained that the biggest problem with mainstreaming was problem behaviors of which they did not know how to deal with (Uysal, 2003). Some teachers believed that the problem behaviors of the students were caused by their disabilities such as mental retardation, learning disability and emotional disorders (Çifci & Tabak, 1997) or personalities (Ađaođlu, 2001), while others attribute these problems to the parents' characteristics or the parents' acceptance of the impairments of the children (Kargin et al., 2005).

The teachers try to control the problem behaviors by using reactive methods such as punishment, warnings and time-out (Özen & Batu, 1997) or having conferences with school counselors and the parents (Sucuođlu, Ünsal & Özokçu, 2004). Conway (1990) suggested that teachers are more likely to see the problem as lying within students than within the school or teaching methods. Similarly, in Turkey, most of the teachers believed that problem behaviors were related to the characteristics of the children and they seemed to be unaware that these behaviors could be related to the school environment or their teaching methods (Kargin et al., 2005). Consequently, very few teachers tried to change these behaviors by using proactive methods such as changing physical arrangements. However, the use of proactive methods affects the student's academic and problem behaviors in a positive way and this could be the starting point for effective teaching (Brophy, 1983; Kounin, 1970; Evertson, Emmer & Worsham, 2003; Murdick & Petch-Hogan, 1996; Niles, 2005; Westwood, 1993).

Just like many other countries, there is limited research on inclusive classroom management in Turkey. Sucuođlu et al. (2004) examined the proactive classroom management of the general education classroom teachers. They divided the teachers into two groups. The first group consisted of teachers whose students displayed many problem behaviors during instruction. These teachers were more likely to complain about the behaviors of the students and attributed these behaviors to the student's characteristics. The second group comprised teachers who were less likely to have problem behaviors exhibited by the students in their classroom and who managed their classroom effectively without complaining to the school psychologist or the principals. Sucuođlu et al. used the Classroom Management Observation Form to assess the

classroom management of the two groups of teachers. The results indicated that the total score for the first group of teachers was less than the second group. Moreover, the first group used less structuring of the classroom and more effective teaching skills than the second group. Although there was no significant difference in how both groups prepared for instruction, the group of teachers who had less problem behaviors exhibited in their class had a higher score than the other group.

Akalın (2007) who conducted the second study focused on the behaviors of students with and without disabilities. The behaviors of both groups of students and also behaviors of the teachers directed students with and without disabilities were compared. The results indicated that there was no significant difference between the behaviors of the two groups of students. Also, the teachers' behaviors towards the students with and without disabilities were not found to be different. Given this background, the purpose of this study was to examine which behaviors of the students with disabilities change according to the classroom management of the regular classroom teachers. The study wanted to answer the following questions: What are the academic, task management and inappropriate behaviors of the children with special needs in general education classrooms in Turkey? Which classroom management strategies are being used by the general education classroom teachers in inclusive classrooms? Which behaviors of the students with disabilities change according to the level of the classroom management of the general classroom teachers?

Method

Participants

Data for this study were collected from elementary school classrooms (grades 1 to five) in which there were at least one or more students with disabilities. Forty four elementary classroom teachers were assessed in terms of their classroom management strategies by using the Proactive Classroom Management Observation Form. These teachers were chosen as they were already taking part in another project focusing on determining the difficulties of the general education teachers who had students with disabilities in their classrooms. Sixty one percent of the group had no training related to mainstreaming or special education whereas 22.7 % of the teachers had either taken one special education course during their undergraduate education or attended a short-term (two weeks) courses provided by the Ministry of Education. Twenty percent of the teachers were teaching at grade 1 level and the other teachers were teaching grade 2 (13.6%), grade 3 (25%) grade 4(22.7%) and grade 5 (18.2%). Although the teachers did not have supports from their schools for teaching inclusive classrooms, all of them were responsible for teaching students with and without disabilities.

The children who participated in this study were diagnosed as having mild mental retardation (31.8%), language and

speech disorder (15.9 %) and mild learning disability (43.2%). Students with severe disabilities were not included in the study because very few children with severe disabilities were accepted into general education classrooms. Only one child with disability was randomly selected as the focus of observation due to the fact that there was more than one student with disabilities in each classroom. Eighteen of the 44 students were girls and the others were boys. Their ages ranged from six to 12 years. All the children with disabilities participated full time in the general education classrooms and they were not provided one to one support by the professionals and volunteers during the school time. Although they had no serious cognitive problems, their academic performance was significantly lower than their classmates without special needs.

Instruments

Proactive classroom management observation form (PCMOF). The PCMOF developed by Sucuoğlu et al. (2004) was revised and used for this study. The researchers added some new items to the PCMOF based on the inclusive classroom management literature (Carpenter & McKee-Higgins, 1996; Marzano & Marzano, 2003; Murdick & Petch-Hogan, 1996) so that they could assess the classroom management of the inclusive classroom teachers. Because the purpose of the study was to assess the classroom management of the teachers who have students with disabilities in their classroom, most of the new added items were related to managing heterogeneous classrooms.

The classroom management of the teachers was assessed by using the PCMOF in terms of classroom rules, procedures and organization, starting instruction, instructional materials, individualizing the instruction, group alerting, using cues and prompts, reinforcing the appropriate behaviors, providing learning opportunities to the students with disabilities, transitions and problem behaviors. The PCMOF has 86 items grouped into 13 subscales. There are two groups of items (positive and negative) in the PCMOF. Seventy four positive items are scored with either 1 (yes) or 0 (no) by the observer, and the range of the scores of this part of the form varies between zero and 74. For example, the first item of the "classroom rules" subscale is "*classroom rules are posted on the wall.*" The observer assesses whether the classroom rules are posted on the place where each child can see easily. If it is so, the observer marks this item and gives one point for it to the teacher.

The second group items (12 items) are scored in an opposite, different way from the first group. In this case if the behavior is exhibited by the teacher or the situation is observed in the classroom, the item is marked by putting (✓) and it is given 0 (zero) for it and if not, that item is scored one. For example, one of the items from problem behaviors subscale is "The teacher is not aware of the problem behaviors exhibited during instruction". If observer sees that the teacher does not notice the problem behaviors exhibited by any of the

children during instruction, the teacher is given (0) points for this item.

Fourteen out of 86 items in the form assess teacher behavior in relation to children with disabilities. For example, item 17 assesses whether the teachers have easy access to the children with disabilities during instruction, and item 67 examines whether the teacher gives praise to children with special needs for appropriate academic or social behavior. Similarly, the observer can determine if the teacher monitors and makes eye contact with the mainstreamed student during teaching by using item 39. Five items (item 38-43), related to the “individualizing instruction” subscale of the form, were assessed by whether the teachers modifies or changes the instruction according to the needs of the children with disability or teaches him / her individually. The items including the classroom management strategies related to the children with special needs are listed in Table 1.

The observation form includes a key which covers the objective definitions of all items. In order to make the assessment easy for observers, many examples were used to explain various teachers’ behaviors and strategies used during instruction, and classroom conditions observed in our classrooms. For example, item 19 which says “The teacher called all the children’s attention including student with disability to the subject before starting instruction” has the following explanation in the key of the observation form “If the teacher had all the children including the student with disability to look at herself/himself or clapped hands or knocked the table or told them to look at her / himself for calling attention and consequently, if the children looked at the teacher or instructional materials, please put a mark near this item. However, if, when all the children give attention to the teacher, the student with disability deals with something not related to the instruction, do not mark this item”. It is believed that this kind of explanation would make it easy to use the observation form which may result in accurate information about inclusive classroom management of the teachers.

Classroom observations were conducted by trained observers during one of the academic classes such as reading, writing, Turkish, math or life sciences. Despite the recommendation that the classroom observation should be conducted for a long period of time, in this study, 44 classrooms were observed only for 45 minutes because, either the principals would not let the observers in classrooms more than one hour, or the teachers did not want to be observed during instruction.

Validity studies. The PCMOF and the key of the instrument were sent to the 10 academicians who study classroom management, special education and elementary school education to examine the content validity of the observation form. Each expert was asked to go over the observation form carefully and evaluate each item by using a 5-point rating system in terms of understandability, language and relevance to the purpose of the study. Then, the means,

standard deviations and coefficient of variation of each item were calculated by the researchers. The items of which the

Table 1

The Percentage of the Teachers who used the Classroom Management Strategies in Inclusive Classrooms

Item number	Items on the PCMOF related to students with disabilities	% of teachers
Item 9	Teacher gave praise to the SWD for his/her following the classroom rules at least one time	0
Item 15	The teacher accessed to the SWD easily during instruction	90
Item 37	The teacher monitored the SWD and made eye contact with them during teaching	54.5
Item 38	The teacher individually worked with the SWD during the class even though, it took very short time	4.5
Item 39	The teacher provided the SWD with having peer support	6.8
Item 40	When the SWD did not understand how to work on given task, the teacher modeled to her /him	43.2
Item 41	The teacher made adaptations in content of the lesson according to the needs of the SWD	6.8
Item 42	The teacher made the SWD actively engaged in academic activities	68.2
Item 43	The teacher provided learning opportunities* with the SWD during teaching	38.3
Item 47	When necessary, the teacher repeated given directions for the SWD and made sure that the SWD understood it	29.5
Item 51	The teacher alerted the SWD by signaling or saying “look here!” during instruction	51.7
Item 58	The teacher made sure that the SWD had made necessary transitions on time	52.3
Item 67	The teacher gave praise to the SWD for at least one or two appropriate academic or social behavior	18.2
Item 77	The teacher checked the homework of the SWD out to be written in his/her notebook	0

Note: SWD = Students with disabilities; * Learning opportunity was defined in two ways for this study: 1. Teacher question/comment + student’s answer /compliance + praise, 2. Teacher question/comment+ no response / wrong response / non compliance + prompt / cue + correct response / compliance + teacher’s praise.

means were greater than 4.25, standard deviation smaller than 1 and coefficient variation smaller than 25% were included in the observation form. That the coefficient of variation is smaller than 25 % indicated that the scores given by the experts were homogeneous (Spigel, & Stephens, 1999). Although the language of some of the items was reviewed, none of the items were excluded from the observation form.

Interrater reliability. Three graduate students from the Special Education Department at Ankara University were trained as observers during the 20 hours training sessions. They were first trained on the items and the key of the PCMOF and afterwards, they watched 3 elementary school classroom teachers' behaviors using the classroom videos until the inter-observer agreement was greater than 90% for each classroom. The classroom management strategies used by the teachers were independently observed by these trained observers over the same period of time and the frequency of the items scored with "yes" by the observers were counted. The reliability levels were calculated by dividing the lower frequency of the higher frequency (Schloos & Smith, 1998). Having met the agreement criteria, the observers were requested to watch the videos of the 44 classrooms and to collect data about proactive classroom management strategies of the teachers.

Internal consistency reliability. Sucuoğlu, Akalın, Sazak-Pınar and Güner (2008) established internal consistency of the form using 191 teachers and the Cronbach α was reported as $r = .80$. This shows that teachers' classroom management strategies can be reliably evaluated by using the PCMOF.

Code for instructional structure and student academic response-Mainstreaming Version/ MS-CISSAR. The behaviors of the children with disabilities were assessed by using MS-CISSAR which is one computerized observation tool of eco-behavioral assessment systems (Carta, Greenwood, Schulte, Arrega-Mayer & Terry, 1988). This instrument is used for observing children with special needs placed in general classrooms and student behaviors are recoded, analyzed and also interpreted in the context of teacher's behavior and ecological variables. Validation studies were conducted by several researchers (Kamps, Leonard & Greenwood, 1991; Rotholz, Kamps & Greenwood, 1989) and it was proved that the instrument was valid for collecting data related to student's behaviors and ecological characteristics of inclusive classrooms.

MS-CISSAR has a taxonomy including three groups of instructional variables, namely student's variables, teacher's variables and ecological variables. Student's variables consist of 23 student responses grouped into three categories such as academic responses, task management responses and inappropriate responses. *Academic responses* reflect academic engagement such as writing, reading, academic talk, task participation and no academic response. *Task management* covers the student behaviors that enable the students to be involved with academic tasks. Raising hand, play appropriately, manipulating materials, moving, talk management attention and no management behaviors were

included in task management. *Inappropriate (competing)* behaviors are those which are against rules, teacher directions and social norms. Competing behaviors are consisting of seven inappropriate behaviors, namely, aggression, disruption, talking inappropriately, self stimulation, looking around, self abuse and no competing behaviors.

Data related to student behavior was collected using a Turkish version of MS-CISSAR (Sucuoğlu, Akalın, & Sazak-Pınar, 2008) in 25 minute sessions for one academic class such as Turkish, reading, writing, math and life science from the classrooms, grades from one to five. The second and third researchers who were trained using a manual, tutorial and sample video of the instrument conducted the calibration and reliability studies. Each observer assessed the student behaviors using videos taken from Turkish classrooms until they attained acceptable inter-observer criteria (i.e. 80%-85%) with the other two observers. Having met the criteria, all classroom videos were watched again, and data on dependent measures were collected by the observers. All students' data were collected using momentary time sampling with specialized computer software through IBM/PC compatible laptop computer.

Results

The Behaviors of the Children with Special Needs

For the purpose of this research, the behaviors of the students with disabilities were determined by using the results of the percentage analysis provided by MS-CISSAR. This computerized program gives the percentages of the behaviors for both; each behavior separately (i.e. writing, manipulating materials or self stimulation, aggression) and groups of behaviors (academic, task and competing behaviors). The results of this study indicated that the students with disabilities displayed a limited number of behaviors during instruction. The most common behaviors among the students with special needs were no academic response (70.10%), no task management (50.88%) and no competing/inappropriate behaviors (62.45%). Writing (academic behaviors) was observed in 11.18% of observation intervals whereas using materials and attention (task behaviors) were observed at 10.49% and 30.29% of the intervals respectively.

When the competing behaviors were examined using percentage analysis, "looking around" was determined to be exhibited during 20.10% of the intervals and "self stimulation" was observed in 10.49% of the intervals during instruction. Clearly, the mostly observed inappropriate behavior among students with disabilities was the "no competing behaviors" (62.45%) during one academic class. The academic, task management and also, competing behaviors exhibited in more than 10% of the intervals of observations are displayed in Figure 1.

Classroom Management of the Teachers

To examine the classroom management of the teachers, the data collected by using the PCMOF was analyzed in two ways. First, the items scored with “yes” by the observers for each teacher were calculated, and a descriptive analysis (total scores, means, standard deviation) for the group was conducted. Then, the percentages of the teachers who were given the score “yes” for each item were calculated and therefore percentages of the teachers who used proactive classroom management strategies were determined.

Despite the fact that the range of the score to be gained from the PCMOF is between 0-86, the results indicated that

the range of the mean scores of the study groups is 22 to 61, the mean of the total score of the group is 38.27 and the standard deviation is 9.50. When the classroom management of the teachers from the different grades were compared by using the Kruskal Wallis Test, it was found that the classroom management of the teachers were not different according to the grades level [$\chi^2(2, N=44) = 1,013, p=.413$]. However, the mean of the total scores of the first and fourth grade teachers were the highest ($m=41$) whereas grade five and grade two teacher’s total scores were the lowest. The mean of the total score of the grade 3 teachers was between the other teachers’ group ($m=37.63$).

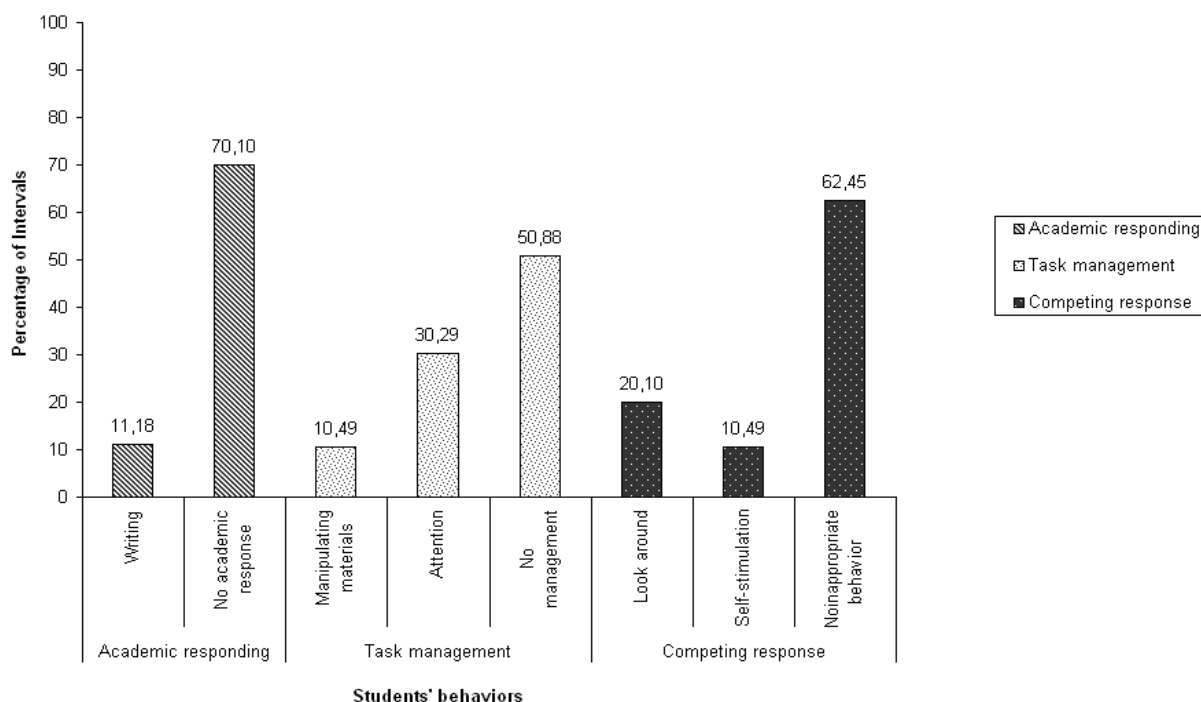


Figure 1. The Percentage of Students’ Behaviors Observed for more than 10% of the Intervals During Instruction

The fourteen items of the PCMOF related to students with special needs were scored with either “yes” or “no” by the observers. The percentage of teachers who got a “yes” is shown in Table 1. This table indicates that none of the teachers gave any kind of praise to the student with disabilities for obeying rules and none checked whether the homework of these students was written in their notebook. A small percentage of teachers worked with the student with disability for 3-5 minutes during instruction individually (4.5%). Seven percent of the teachers provided peer support for the student with disabilities for the academic activities and also, approximately seven percent of them modified the content of instruction according to the needs of these students. In contrast, of all teachers who accessed the students during

instruction, 54.5% of them monitored the children with special needs, made eye contact with them, modeled for them for the difficult tasks (43.2%) and had them actively engaged in academic activities (68.2%) even though these activities were not adapted according to needs of the children. Approximately 30% of the teachers gave the students learning opportunities, while only 18.2 % of them praised the children with disabilities for appropriate academic or social behaviors.

With respect to the teachers’ overall classroom management, the results demonstrated that less than 15 % of the teachers had established the rules, praised the students who followed the rules or reminded them of the consequences of not complying with the rules. Only 10 % of the teachers provided instructional materials to be seen and used by all the

students, including students with disabilities, during instruction. Furthermore, when the students exhibited any problem behaviors during class, some of the teachers (36%) either ignored these behaviors, or frequently used reprimands. Most of the teachers (approximately 90%) used clear and easily understandable directions and monitored all the students including the student with disabilities (80%), while they were teaching. Ninety percent of the teachers alerted students during instruction by questioning or saying “look at me”.

Behaviors of the Students with Disabilities and Classroom Management of the Teachers

In an attempt to answer the last question of the study, the teachers were assigned to the three groups based on their level of the classroom management. The low classroom management group included the teachers whose scores fell between 21 and 30, while the range of the medium and the high management groups' scores were 31 to 41 and 43 to 61 respectively. Because of the fact that there were three groups of students with disabilities whose teachers managed their classrooms in different levels, the total percentages of the behaviors of the students from high, medium and low classroom management group were compared using the Kruskal Wallis Test. The percentages of the total academic, task and competing behaviors of the students were provided from the MS-CISSAR computerized program. The students' behaviors were the dependent variable for the study, while the level of the classroom management of the teachers was the independent variable.

According to the results of the analysis, there was no significant difference between the academic behaviors of the students with disabilities of the high, medium and low classroom management groups [$\chi^2(2, N=44) = 1.613, p = .446$]. On the contrary, the task behaviors of the three groups of the students were found to be significantly different [$\chi^2(2, N=44) = 9.388, p = 0.009$]. The means of the percentage of the task behaviors of the first and third groups were the same, while the percentage of the second group was lower than the other two. This finding revealed that the task management behaviors of the students differed according to how their teachers managed their classrooms. The problem behaviors of the three groups of the students with disabilities were differed significantly [$\chi^2(2, N=44) = 7.046, p = 0.30$] and the percentage of the competing behaviors of the students from the medium level classroom management group was higher than the other groups.

Discussion

The current study was conducted in an attempt to investigate whether the academic, task management and competing behaviors of children with disabilities placed in general classrooms were affected by the classroom management of the teachers. The study yielded three important findings in regard to the classroom management of

teachers and behaviors of students in inclusive classroom. First, children with disabilities exhibited a few behaviors during instruction in one academic class such as math, Turkish and life sciences. “No task management”, “no academic behaviors” and “no competing behaviors” were the most observed behaviors, while “writing” and “using materials” and “attention” were the behaviors in which the children engaged the most. Previous studies focusing on the behaviors of the students with disabilities in inclusive preschool and high school classrooms demonstrated that “writing” was the most observed academic behavior, while “passive attention”, such as looking at the teacher or the other students, asking or answering questions, and “using materials”, was observed as the most exhibited task management behaviors (Smith, Robinson, Arthur-Kelly & Morgan, 2004; Wallace, Reschly-Anderson, Bartholomay & Hupp, 2002). However, it is difficult to compare the results of this present study with the others, because, in these studies, “writing” and “reading silently” were grouped as academic engagement and academic behaviors were assessed as a group instead of assessing each academic behavior separately (Logan, Bakeman & Keefe, 1997; Logan & Malone, 1998; Smith, Robinson, Arthur-Kelly & Morgan, 2004; Wallace et al., 2002).

Previous studies state that most of the teachers of inclusive classrooms generally complain about inappropriate behaviors of students with disabilities and they do not prefer having these children in their classrooms (Blanton, Blanton & Cross, 1993; Hanrahan et al., 1990; Özen & Batu, 1997; Uysal, 2003). However, results of this current study revealed that the mostly observed competing behaviors during instruction were “no competing” behaviors. “Looking around” and “self stimulation” were the only competing behaviors in this study; similar to the findings of previous studies (Smith, Robinson, Arthur-Kelly & Morgan, 2004; Wallace et al., 2002). These results may suggest that the competing behaviors of the children were not as intensive as the teachers had stated. Extant research emphasize that if the students are not engaged in academic behaviors and task behaviors during instruction, their competing behaviors are most likely to increase (Brophy & Good, 1986; Jones & Jones, 2001; Kounin, 1970). Taking these results into consideration, it appears that the teachers do not want these students in their classes; not only because of the amount and the types of the problem behaviors but also because of limitations of their knowledge and experience in terms of dealing with competing behaviors in inclusive classrooms.

The second finding of the study indicated that regular classroom teachers in Turkey have various difficulties and strengths related to effective classroom management in inclusive classrooms. For example, although the clearly defined classroom rules are very important elements of classroom management (Emmer & Stough, 2001; Carpenter & McKee-Higgins, 1996; Shores, Jack, Gunter, Ellis, DeBriere & Wehby, 1993; Simeonsen et al., 2008), it was found that most of our teachers did not establish the rules and procedures for their classrooms, and they did not explain to their students

the consequences of not complying with those rules. Instead, when they encountered the inappropriate behaviors of any of the students, including students with disabilities, during instruction most of the teachers warned them several times or preferred to ignore the behaviors. Moreover, none of the teachers modified the content of the curriculum according to the needs of their students with disabilities and only a small number of the teachers were found to have allocated a few minutes to teach the SWD during class. Only five percent of the teachers provided peer support to them, and none of them praised the students with disabilities for following the rules, for at least one time in the class. Furthermore, only 18.2% of the teachers praised the students on displaying appropriate social or academic behaviors. These results seem to be consistent with existing Turkish literature indicating that the teachers appear to have serious difficulties regarding classroom management; not only in inclusive classrooms but also in classrooms without SWD (Atıcı, 2000; Turnuklu, 2000). Therefore, it is believed that the findings of the current study have reflected the teachers' classroom management style in the cultural context and educational system in Turkey.

In interpreting these results, some factors should be taken into account. First, in Turkey although mainstreaming was accepted as an appropriate educational model for students with disabilities by the policy makers or by the Ministry of Education, the quality and quantity of support services for teachers and students with disabilities have not been improved well enough yet. Therefore, the majority of general classroom teachers cannot be provided necessary support for teaching in inclusive classrooms. The teachers are strained when teaching students with disabilities, especially in heterogeneous classrooms, and they do not know how to cope with classroom management problems of students of different ability levels. Secondly, in spite of the fact that the general classroom teachers participate in several training programs conducted by the Ministry of Education about the needs of students with disabilities and mainstreaming, most of the training programs are short term-didactic courses based on lectures. Therefore, the teachers are usually not given the practical and functional information, with which they can use for managing inclusive classroom and teaching heterogeneous classrooms. Furthermore, both undergraduate and graduate teacher training programs mostly focus on how to teach or how to implement instructional techniques instead of how to manage the classroom so that the teachers could successfully teach all students. It is believed that our results may lead experts and professionals who are responsible for planning and developing in-service programs for inclusive classroom teachers to be aware of the areas in which they have difficulties regarding managing heterogeneous classrooms.

The result of the analysis related to the main purpose of the study indicated that the academic behaviors of the students did not change according to the level of the classroom management of the teachers as expected. In other words, there were no significant differences between the percentages of the academic behaviors displayed by the SWD of the high,

medium and low classroom management groups. This finding is contrary to the findings of other studies (Larivee, Algina, 1983; Sanders & Rivers, 1996; Wright, Horn & Sanders, 1997) that emphasized that teachers could make a difference on students academic achievement. In extant literature, it was frequently indicated that academic achievement and engagement of the students could be varied according to behaviors of the teachers (Bulgren & Carta, 1992; Carta, Atwater, Schwartz & Miller, 1990; Evertson, 2001; Greenwood & Carta, 1987). However, in this study, the researchers were not able to access accurate information related to academic success of students with disabilities from elementary schools due to insufficient data in that regard, and therefore, the percentage of the academic behaviors displayed by the SWD was accepted as the dependent variable of the study. The researchers concluded that if academic achievement of students with disabilities were examined instead of academic behaviors, classroom management of the teachers might have been found as an effective variable on students' academic success.

According to the last finding of the study, the task behaviors and the competing behaviors of the students with disabilities were affected by the teachers' classroom management. Although it was expected that the percentage of the competing behaviors displayed in high classroom management group would be lowest, the competing behaviors of low and high classroom management groups were found to be less than the medium classroom management groups. That is, the students from the classrooms whose teachers had medium level classroom management exhibited more competing behaviors than the two other groups. This finding contrasts previous studies which state that there is a strong relationship between students' inappropriate behaviors and teachers' classroom management, and while the effectiveness of the classroom management improved, the inappropriate behaviors of the students mostly decreased (Anderson, Evertson, Borphy & 1979; Brophy & Evertson, 1976, Good & Brophy, 2003; Sutherland et al, 2008; Westwood, 1993. Nevertheless, in this research, the students in the low classroom management group displayed competing behaviors equivalent to the high management group and less competing behaviors than the medium group.

Several factors could have contributed to these results. The most important factor was that the data related to both the students' behaviors and the teachers' classroom management were collected in one academic class due to problems of having observations during instruction in classrooms, contrary to the other research, in which observational data were collected in longer periods such as four or five sessions or classes (Carter, Sisco, Brown, Brickham & Al-Khabbaz, 2008; Hollowood, Salisbury, Rainforth, & Palombaro, 1994; McDonnell, Thorson & McQuivey, 1998). Therefore, the results of this study might have been affected by the duration of the observations. In the future, if the data is collected during longer observational periods, the research might yield different patterns of the relationship between teachers'

classroom management and the students' behaviors for consideration.

The second limitation of this current study is that the data regarding the behaviors of the students with disabilities were not compared with that of students without disabilities. However, because there are no standards or norms for the frequency or percentage of the academic behaviors displayed by students with disabilities in the classroom, it is difficult to decide how many behaviors could be accepted as sufficient for benefiting from instruction in inclusive classrooms for students with and without disabilities. For this reason, if future studies compare the percentage of the behaviors of the students with and without disabilities, this kind of comparison might shed light on the relationship between Turkish students' behavior and teachers' classroom management in a wider perspective.

In conclusion, this current study can provide a profile of classroom management of teachers who have students with disabilities in their classrooms and can give us important information on what may be happening in heterogeneous classrooms. These researchers believe that classroom management should be considered as a powerful cluster of techniques and strategies in terms of creating meaningful learning experiences for all students including students with disabilities, because, in Turkey, there are a limited numbers of experts working in special education collaborating with the general education teachers for meeting the needs of students with disabilities. Therefore, both pre-service and in-service teachers should be trained in proactive classroom management so as to teach all students regardless of their ability levels, and to handle problems more effectively. Clearly, there is need for more research focusing on knowledge and skills of teachers in terms of managing their classrooms effectively and modifying instruction that could enhance learning opportunities for all students. More attention should be paid to some areas of inclusive classroom management such as organizing classrooms for all students, praising social and academic behaviors of the students and adapting and modifying instructions according to the needs of all students while working with the classroom teachers.

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Risks/Needs of Children/Youth with Behavior Disorders in Correctional Institutions in Croatia

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Abstract

Previous research and experience in Croatia show that interventions are not matched with the risk level and intervention needs of children with behavior disorders. As a result of that, the situation in Croatia requires actuarial approach to the risks and needs assessment of children and youth. The purpose of the current research is to put stronger and more explicit emphasis on the intervention system for children and youth at-risk oriented towards the rights and needs of those children and youth. The purpose of this paper is to examine the differences between children and youths in various kinds of institutions regarding level of risks and strengths. The sample consisted of 418 children/youths with behavior disorders from 14 institutions. Youth Level of Service/Case Management Inventory (Hoge, Andrews & Leschied, 2002) was used to assess eight areas of risk and need. The results indicate that children in various types of institutions have specific needs regarding their risk level.

Introduction

Background Information about the Republic of Croatia

The Republic of Croatia is a country located in Southeastern Europe with around 4.5 million inhabitants. Croatia is administratively divided into 21 counties. The legal system has mostly grown out from Austro-Hungarian legal system. The number of children in Croatia is around 950.000 (Central Bureau of Statistics, 2009). Approximately 25% of the total population, due to their specific characteristics, demands special protection and care. The expression “children” is defined in accordance with the Convention on the Rights of the Child (UN, 1989) and implies a group of people up to 18 years of age, while according to the Croatian legal system, a child is every person up to 21 years of age (Juvenile Courts Act, NN, No. 111/97).

Definitions of Behavior Disorders

One of the first definitions of behavior disorders presents joint expression for all phenomena of biological, psychological and social genesis that adversely affects one’s activity and has both negative and dangerous influences on individuals and their surroundings (Dobrenić & Poldrugač, 1974). Uzelac (1995) further explains that the expression “behavior disorders” encompasses children who violated law (juvenile delinquents) as well as children who violated

specific, socially accepted behavior (such as running away from home, or truancy).

Croatian definitions of behavior disorders can be compared to the DSM IV classification in the category of *conduct disorders* (conduct disorder, oppositional defiant disorder, aggressive conduct, adjustment disorder with combined emotional and behavior problems, adjustment disorder behavior problems and antisocial behavior of children and adolescents).

Due to the fact that behavior disorders develop gradually, mostly from mild to more intensive forms, intervention systems should also be progressive in order to help the young persons deal with challenging issues that often lead to disorderly conduct. Both law and everyday practice are led by the idea of a progressive system of interventions when it comes to protection, care and treatment of children.

Interventions for children/youth with behavior disorders in Croatia are regulated by three acts: Juvenile Courts Act (OG, No. 111/97), Social Welfare Act (OG, No. 73/97) and Family Law Act (OG, No. 116/03). The Juvenile Courts Act enables treatment progression while the other two acts do not mention that differentiation of placement and population classification. That leads to the fact that children with the same or similar problems could be placed in different types of institutions (Žižak & Koller-Trbović, 1999). This is illustrated in Table 1.

On the grounds of the three acts stated before, the institutional treatment for children with behavior disorders in Croatia is performed in the following institutions: Specialized Children's Homes (these are a special units of the Children's Home Zagreb and an intensive treatment group), Community Residential Homes (there are seven of these in Croatia), State Residential Homes (there are three of these, one for girls only and two for boys only), Correctional Institutions (one for girls and one for boys) and one Institution for youth with Multiple Problems.

Table 1

Review of Residential Treatment Interventions for Children/Youth According to the Specific Acts in Croatia

Act	Interventions
Social Welfare Act	Extra-familiar care that includes all forms of placement
Family Law Act	Child with behavior disorders can be placed in social welfare institution for care and upbringing
Juvenile Courts Act	Referral to a Correctional Institution Referral to a Reformatory Referral to a Special Correctional Institution

Assessment of Risk

Bonta and Andrews (2007) stated that without standardized, quantifiable methods of assessment, programs are limited in their ability to match clients to the appropriate services. One of the important principles of classification is the risk principle, which states that the level of service should be matched to the risk level of the offender. In relation to that, Simourd, Hoge, Andrews and Leschied (1994) claim that the accurate assessment of risk/need factors is important for the development of case classification systems that are used to classify youths according to their risk of deviant behavior and specific treatment needs. Lipsey and Wilson (1998), as cited in Matthews, Hubbard & Latessa, (2001) noted that effective intervention requires a good match between program concept, host organization and clientele targeted. Hsia and Beyer (2000) as cited by Hoge, Guerra and Boxer (2008) also mentioned the benefit of a comprehensive approach to needs assessments that could guide placement, supervision, and treatment decisions. Hoslinger, Lowenkamp and Latessa (2006) mentioned some of the advantages of standardized risk assessment concerning juvenile justice and social welfare systems; matching risk level of youth with the appropriate

level of services can help in the development of successful intervention programs. Empirically based risk assessment instruments can serve as benchmarks for program development and also for the measurement of program quality. Hoge and Andrews (2006) defined a set of risks that have an influence on the development of behavior disorders and in accordance with that the authors developed an assessment instrument named Youth Level of Service/Case Management Inventory.

Previous research and experience in Croatia show that interventions do not match the risk level and intervention needs of children with behavior disorders. Experts in Croatia advocate for interventions for children that would be based upon quality and comprehensive assessment of risk and needs and delivered at appropriate times. This is especially important because, according to Jaman (2008) placement in a certain institution is not often defined by a child's treatment needs or by compatibility of the child's needs with treatment that can be provided in a certain institution. Regarding the assessed risk and needs of children, relevant Croatian experts clearly advocate changes in the system of care and treatment of children with behavior disorders in the direction of differentiation of institutions and services in residential treatment in order to establish new programs that can serve different needs of certain groups of children (Bouillet, 1998; Žižak & Koller-Trbović, 1997, 1999; Koller-Trbović, Žižak, & Bašić, 2001; Žižak, 2001). This paper can possibly give these efforts a meaningful starting point.

Goal and Hypothesis of the Study

The purpose of this study was to examine the differences between children and youth in various types of institutions regarding levels of risk and strengths of children. Specifically, this research wanted to determine characteristics of children and youth and their assessment of risks and needs in relation to the treatment provided. The hypothesis of this study is that there are significant differences in assessed risks and strengths (using Youth Level of Service/Case Management Inventory) of children/youth in different types of residential treatments in Croatia. While the different types of residential institutions in Croatia should provide a different treatment matched with the risk and needs of beneficiaries, it can be assumed that in different treatment institutions children and youth have different risk and need profile. It is important to notice that age and some other demographic characteristics are also important while providing a treatment, and can influence level of risk/need. Through this analysis it is expected that each type of residential treatment program would have a specific risk/need profile of the treatment beneficiaries.

This research study was part of a broader research which is titled *Matching Interventions with the Needs of Children at Risk: Creating a Model*, and it was financed by The Ministry of Science, Education and Sports in the Republic of Croatia. The whole project was conducted by the Department of Behavior Disorders, Faculty of Education and Rehabilitation

Sciences, University of Zagreb, and the project leader was Antonija Žižak (Ph.D). The main goal of the project was to propose an intervention model for children with behavioral disorders or those at risk of developing behavioral disorders, primarily within the welfare system, which would be based on the scientific assessment of psycho-social risks and the intervention needs of the users. The project started in 2006, and was still in progress during the time of this research.

Method

Participants

In order to screen children and youth with behavior disorders who were currently placed in the institutional treatment comprehensive risk level and intervention needs assessment were done. The sample consisted of 418 children and youth from all 14 institutions, which were categorized into 5 groups: Correctional Institution (19% of the sample, n=1), State Residential Homes (29% of the sample, n=2), Community Residential Group Homes (42% of the sample, n=7), Institution for youth with multiple problems (8% of the sample, n=1) and Specialized Children Homes (11% of the sample, n=2). The average age of children/youth was 17 years (age range from 9 to 22) and 83% of them were male. Almost equal percentages of the children/youth attended elementary (39%), and secondary (38%) schools. There was a big difference between average ages of beneficiaries placed in various types of institutions. In line with that, the average age of beneficiaries from correctional institutions was 17.8 years, from state residential homes 16.8 years, from community residential homes 15.8 years, from Institution for youth with multiple problems 17 years and from Children Homes 13 years.

Instrument

A well known assessment instrument Youth Level of Service/Case Management Inventory (YLS/CMI) (Hoge, Andrews & Leschied, 2002) was used. Permission to use the instrument for the purpose of the research was obtained from Multi - Health Systems Inc. – Customer Number 135920. This instrument was used for the assessment of risk, needs and strengths of children/youth and their environment with the purpose of the projection of individualized treatment. The instrument enables the identification of risk levels for socially unacceptable behavior as well as the areas of strengths. It is based on the Risk – Need – Responsivity (RNR) model (Hoge & Andrews, 2006). Risk factors are attributed to an individual and his/her environment.

The first part of the Instrument “Assessment of Risks and Needs” consists of 42 items, with dichotomous variables. The items are divided into eight subscales as following: (1) Prior and Current Offenses (items related to prior convicting and offending, prior dispositions, sometimes even residential placement); (2) Family Circumstances/Parenting (items related to inadequate parental supervision, inconsistent parenting,

inappropriate discipline style and poor relations with mother or father); (3) Education/Employment (difficulties in education, disruptive classroom behavior, problems with peers and teachers and low achievement); (4) Peer Relations (friendship with delinquent peers and having no/few positive acquaintances describes risks in the peers area); (5) Substance Abuse (occasional or chronic drug and alcohol abuse are emblematic risk behaviors); (6) Leisure/Recreation (limited personal activities, no interests, could make a better use of time); (7) Personality/Behavior (verbally or physically aggressive, problems with attention, poor frustration tolerance) and (8) Attitudes/Orientation (antisocial attitudes, defies authority, not seeking help or rejecting help).

Depending on the area, the score of a certain area consists of different number of items, from three to seven items. This instrument gives an opportunity to assess strengths in all the above areas except the first one. Other sections of the instrument provide information about responsivity factors (other family and youth needs and special considerations) and recommendations regarding the level of service, goals of intervention, and means for achieving those goals. The Instrument Youth Level of Services/Case Management Inventory (YLS/CMI) was translated and adapted for implementation in Croatia in 2007. The main changes in the Croatian version were made in the first area (prior and current offenses) and the fifth area (estimation of treatment adequacy and effectiveness were added). Metric characteristics of YLS/CMI used on Croatian population show high reliability ($\alpha = 0.872$; $R_{IT} = 0.858$).

Procedure of the Screening

The whole population of children and youth in different types of institutional treatment was screened between 1 February 2008 and 31 March 2008 in the Republic of Croatia. Professionals (social pedagogues, social workers, and psychologist) from institutions named above had completed questionnaires. Prior to the assessment, these professionals were specially trained to use the instrument. The training was provided by the project team and consisted of a presentation on the risk-need approach, detailed instructions for implementation of the instrument and exercise of the assessment procedure. After the training, professionals assessed the children/youth in their institutions and forwarded completed instruments to the project team for data analysis.

Data Analysis

The program *Statistica* was used for all the statistical analyses. *RTT.stb* program (Dizdar, 1999) was used for the verification of reliability and validity of the instrument. The Robust discriminant analysis (Nikolić, 1991) was used for the determination of characteristics and for the identification of differences between subsamples. With this method it is possible to identify the differences between the samples and criterion for comparison was the type of the institution. Based

on the Kolmogorov – Smirnov test a distribution of the sample showed some deviations of the normal distribution in some areas of the instrument. This is the reason why a variation of discriminant analysis, called robust discriminant analysis, was used. Analysis of variance examined any significant differences between subsamples, and discriminant analysis provided latent dimensions or factors which were responsible for the discrimination.

Discriminant analysis and analysis of variance are methods based on mutual correlation of variables, more precisely, on analysis of differences (Mejovšek, 2008). Using these analyses, differences between samples in one or more dependent variables can be established. Because this research consisted of only one dependent variable (YLS/CMI result) a univariate analysis of variance was used. The differences were introduced through a specific structure of variables responsible for distinction (Mejovšek, 2008).

Since this research sought for differences among five groups, it was possible to expect four discriminant factors. Before graphic multidimensional presentation of relationships between the factors using the *Sigma*plot program, values were standardized with the same program.

Results

First the results concerning risks will be presented followed by the results concerning strengths of children/youth. The results indicated differences of children/youth in different types of institutions regarding risk levels and estimated strengths but not enough recognizable differentiation of the treatment.

Risks

An overall risk score of YLS/CMI was computed. The total risk score was computed by summing the subscores. Four categories of overall risk scores are provided: low, moderate, high, and very high. An overall risk level is relevant when deciding necessary security and the level of service.

Generally, when observing the whole sample, 60% were estimated to function on a moderate level of risk and 30% on a high level of risk (see Table 2). A small percentage of the population was estimated to function on low and very high levels of risk. In the YLS/CMI risk areas, level of risk can be estimated as low, moderate and high. Also, risk levels on subsections could be a pattern of the most relevant needs for the case planning.

One half of the sample was assessed on low level of risk in two risk areas (prior and current offences and substance abuse). In three risk areas (Peers, Personality/Behavior and Attitudes/Orientation) more than a half of the sample had results which responded to a medium level of risk. The highest results are in the family area, leisure/recreation and education categories (see Table 3). The results of the univariate analysis of variance showed that it is possible to determine if there are specific characteristics of children/youth in different

institutional types of treatment (see Table 4). Statistically significant differences among children/youth placed in five types of institutions were obtained in five out of eight assessed risk areas. These areas are: prior and current offence, family, education, peers and substance abuse. Youth placed in

Table 2

Total Level of Risk	Total Sample Size (%)
Low	7.7
Moderate	60.5
High	29.9
Very High	1.9

Distribution of the Results on the Total YLS/CMI Score (N = 418)

the correctional institution were estimated as having a high level of risk in all five significant areas. Youth from state residential homes and institution for youth with multiple problems reach the high level of risk in family, education and peers categories, as well, and medium level of risk in prior and current offence and substance abuse categories. Seemingly, children and youth from community residential homes and children's homes have the same level of risk in the same areas – high level of risk on the family and education area and medium level of risk on the prior and current offence, peers and substance abuse areas.

It seems that high level of risk in the area of family life and education is the general key reason for placing children/youth in institutional treatment, and that *differentia specifica* among these institutions could be found in risk areas of substance abuse, peers and prior and current offence.

Through the implementation of robust discriminant analysis, a latent level of discrimination between children/youth in five types of institutions was identified within the specific risk levels.

As could be seen from Table 5 three significant discriminant functions were found. The first discriminant function was strongly defined by the prior and current offenses areas and substance abuse so it was named “delinquency” (see Table 6). The second discriminant function was strongly defined by three areas – family, peers and personality, so this function was named “risk relations and personality”. The third discriminant function was defined through leisure/recreation and substance abuse area so it could be named “risky style of spending leisure time”. Table 5 and Figure 1 indicate how subsamples are defined by these three discriminant functions. Children/youth in correctional institutions were the mostly defined by discriminant function “delinquency”, and latter

with “risky style of spending leisure time” and “risky relations and personality”. Children/youth from state residential group homes were defined with all three discriminant functions, in the same proportion. Children/youth from community residential homes are defined to a larger extent by risky style

of spending leisure time. Children/youth from Specialized Children’s Homes are defined with risk relations and personality, and then with risky style of spending leisure time.

Table 3

Distribution of the Results on YLS/CMI Subscales Regarding Risk Scores (N = 418)

YLS/CMI Risk Areas	Low (%)	Moderate (%)	High (%)
Prior and Current Offence	48.3	36.8	14.8
Family Circumstances/Parenting	14.4	30.9	54.8
Education/Employment			
Peer Relations	15.8	35.6	48.6
Substance Abuse	22.7	50.7	26.6
Leisure/Recreation	47.6	35.4	17.0
Personality/Behavior	12.4	35.9	51.7
Attitudes/Orientation	6.9	60.5	32.5
	16.5	65.1	18.4

Table 4

Analysis of Variance for Areas of Risk

Areas of risk	Mean					F	P
	Correctional Institution	State RH	Community RH	Children’s Home	IYMP		
Prior and Current Offence	2.43	1.65	1.56	1.04	1.34	83.10	0.000
Family Circumstances/Parenting	2.62	2.36	2.28	2.63	2.37	10.65	0.000
Education/Employment	2.25	2.20	2.38	2.50	2.34	4.80	0.001
Peer Relations	2.55	2.18	1.77	1.96	2.06	2.25	0.000
Leisure/Recreation	2.43	2.32	2.40	2.26	2.43	17.83	0.062
Attitudes/Orientation	2.51	1.93	2.02	2.00	2.03	0.75	0.562
Personality/Behavior	2.21	2.13	2.26	2.43	2.43	2.97	0.019
Substance Abuse	2.13	1.68	1.54	1.15	1.60	57.25	0.000

Note: RH = Residential Home; IYMP = Institution for youth with multiple problems; p>.001

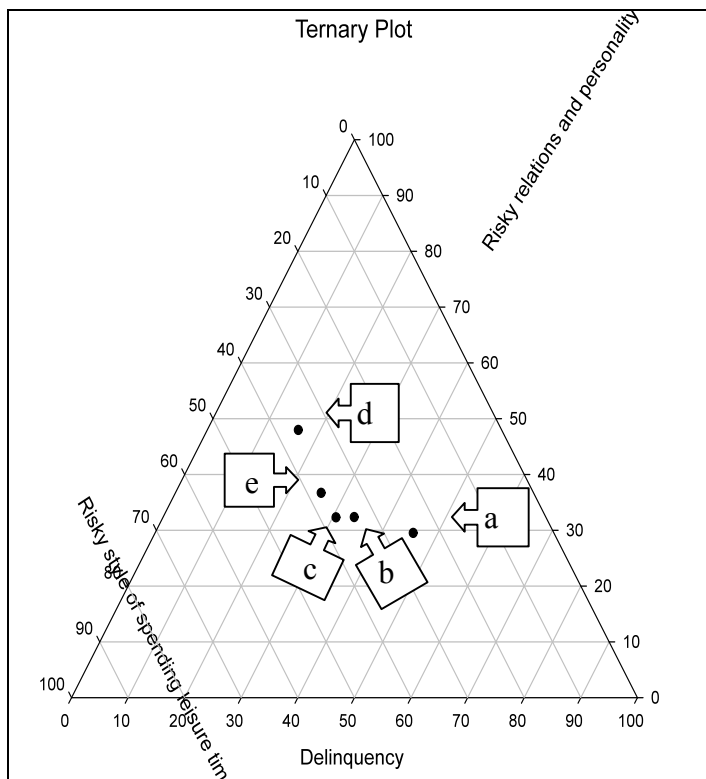


Figure 1. Centroides of Subsamples on the Discriminatory Functions. Note: a = Correctional institution; b = State residential home; c = Community residential home; d = Children's home; e = Institution for youth with multiple problems; To read the values, it is necessary to follow the arrows

While Tables 5 and 6 can serve for determination of characteristics and specificities of children/youth in observed types of treatment, Figure 1 shows their relationship and dimensional position in relation to three identified discriminant functions.

Strengths

Children/youth strengths are most frequently assessed by the professionals in the family area (35.4%), leisure/recreation area (30.9%) and in the education area (29.2%) (see Table 7). Youth placed in correctional institutions are assessed as having a high level of risk in all the significant risk areas and not having any strength. State residential homes have the biggest variety of estimated strengths. State residential homes and institutions for youth with multiple problems are specific due to the estimated presence of strengths in the family, education and peers areas. Negative attitude regarding substance abuse is present in community residential homes. Children placed in children's homes were assessed as having strength in the peers area. Youth placed in a correctional institution were assessed as having high level of risk in all the significant risk areas and not having any area of strength.

Using Univariate Analysis of Variance, specific characteristics of children/youth in different institutional types

of treatment were determined. Statistically significant differences among children/youth placed in five types of institutions were obtained in all seven assessed strengths areas. As with the assessed risks, when applying discriminant analysis, a latent level of discrimination between five types of institutions was identified regarding specific strength areas. Discriminant analysis displays differences among institutions according to the child/youth strengths. Three statistically significant functions discriminate five types of treatment institutions.

Correlations of each variable with discriminant functions (see Table 8) show the participation of the biggest number of strength areas (family, education, peers, leisure/recreation and personality/behavior) in defining a first discriminant function. It can be defined as "multiple areas of strengths". Areas of substance abuse and attitudes/personality define a second discriminant function and it can be named "prosocial attitudes". Third is the mostly defined by peers area, so it can be named "prosocial peers". Centroides show the position of children/youth from those types of treatment on discriminant functions, which can be seen in Table 9. The results of children/youth from correctional institutions have negative correlation with all three discriminant functions, which can be explained as an absence of assessed strengths. Children/youth from state residential group homes are defined with the first discriminant function "multiple areas of strengths". Children/youth from community residential home are defined with the function "prosocial attitudes". A similar situation was found with children/youth from institutions for youth with multiple problems. The same discriminant function ("prosocial attitudes") was positively correlated and the other two discriminant functions were negatively correlated with that type of institution. The third discriminant function, called "prosocial peers" defined children/youth from Children Homes. Figure 2 shows their relationship and dimensional position in relation to three identified discriminant functions.

Using risk areas and strengths as a criterion, sample could be differentiated as following: Youth from correctional institution have a high risk in the area of prior and current offenses, family, education, peers and substance abuse and no specific strengths were recognized. Children/youth from State residential group homes and special institutions for youth with multiple problems had a high risk in the area of family, education and peers and medium level of risk in the area of prior and current offences and substance abuse, and assessed strengths in almost all areas. Children/youth from community residential homes and children's homes had a high risk in the area of family and education and medium risk in prior and current offenses, peers and substance abuse. Estimation of strengths in the substance abuse area is a specificity of children/youth from community residential homes while for children/youth from children's homes estimation of strengths

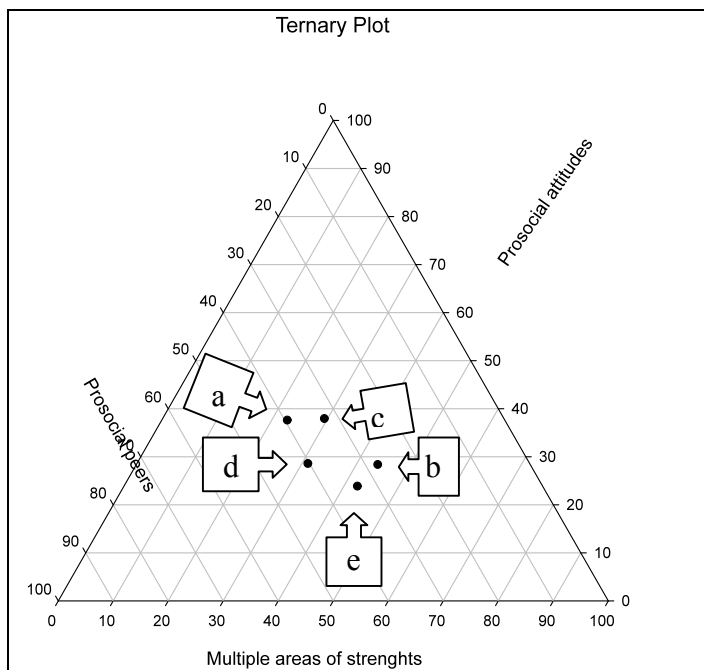


Figure 2. Centroides of Subsamples on the First Discriminatory Function. Note: a = Correctional institution; b = State residential home; c = Community residential home; d = Children's home; e = Institution for youth with multiple problems; To read the values, it is necessary to follow the arrows

Institutions	Estimated High Risks in Areas	Estimated Strengths
Correctional Institution	- Prior and current offence - Family - Education - Peers - Substance abuse	
State Residential Home	- Family - Education - Peers	- Family - Education - Peers
Community Residential Home	- Family - Education	- Substance abuse
Children's Home	- Family - Education	- Peers
Institution for Youth with Multiple Problems	- Family - Education - Peers	- Family - Education - Peers

Figure 3. Parallel Comparison of Estimated Results in Risk and Strength Areas.

was in peers' area. Through parallel comparison of estimated results in risk and strength areas, characteristics of the population were reviewed as illustrated in Figure 3.

Discussion

A general impression, when looking at the results, is that professionals in Croatian institutional treatment are more oriented towards risks than to strengths of children. Youth placed in the correctional institution were assessed as having a high level of risk in all the significant risk areas and not having strengths. It should be mentioned that all these results were the estimations of professionals. However, this did not mean that those children/youth did not have strengths, but simply that the strengths had not been recognized and assessed. This result opens up a question of the standard and the quality of the assessment. According to Hoge, Guerra and Boxer (2008), within populations of relatively high-risk youth, the risk principle may be less relevant, and assessment may consider other factors. Because of this, it is very important to recognize strengths. Strengths and risks were recognized in the same areas in both state residential group homes and institutions for children with multiple problems. This could be a characteristic of professionals' assessment - while they estimating the risks they seek for strengths. This could also lead to a higher level of quality concerning treatment programming.

Results from this research can be compared with the research of Schwalbe, Macy, Day, and Fraser (2008). Schwalbe et al. distinguished five types of offenders and the class with the highest scores differed from other classes by higher average scores in substance abuse and peer delinquency. In our research, youth from correctional institutions were estimated with the highest scores in all assessed areas and their distinction from others was higher scores in prior and current offenses, substance abuse and partially in the peers' area. The estimated specificities could be a base for treatment programming. For example, it could be determined which dynamic areas every institution needed to orient its programming and treatment to.

Taking into account the hypothesis of the study, the results present the complexity and gradation in the severity of the phenomena regarding types of treatment differences, but the results did not show the specificities in risk areas which could be a base for the differentiation of treatment. Through this research differences between types of existing institutional treatment were established. The results showed some specific characteristics but not enough recognizable profiles of children/youth in different types of treatments. Recognizable profiles would ensure the matching of needs of children/youth with institutions and treatment programs that those institutions provide. Since these profiles were not provided, it is necessary to create a treatment-programs differentiation which could address the treatment needs of beneficiaries.

Table 5

The Results of Robust Discriminant Analysis on Risk

Institution	Centroids Discriminant Function		
	Delinquency	Risk Relations and Personality	Risky Style of Spending Leisure Time
Correctional Institution	1.64	0.33	-0.03
State Residential Home	0.07	0.04	0.06
Children's Home	-0.37	-.03	0.49
Community Residential Home	-1.15	0.49	0.22
Institution for Youth with Multiple Problems	-0.42	0.22	0.28
F	100.52	6.80	4.99
P	0.000	0.000	0.001

Note: $P < .001$

Table 6

The Structure of Discriminatory Functions

Areas of Risk	Discriminant Coefficients		
	Delinquency	Risk Relations and Personality	Risky Lifestyle of Life Spending Leisure Time
Prior and current offence	0.69	-0.25	-0.42
Family circumstances/Parenting	0.05	0.60	-0.58
Education/Employment	-0.12	0.14	-0.34
Peer Relations	0.34	0.61	0.29
Substance abuse	0.60	0.02	0.34
Leisure/Recreation	0.10	-0.05	0.36
Personality/Behavior	-0.15	0.41	0.33
Attitudes/Orientation	0.08	0.12	-0.07
Discriminant Function	4.31	0.49	0.10

Table 7

Comparison of Assessed Strengths Between the Institutions (N = 418)

Strengths	Correctional Institution (%)	State RH (%)	Community RH (%)	Children's Home (%)	IYMP (%)	Total (%)
Family Circumstances/Parenting	13.00	53.57	19.89	23.91	51.40	32.35
Education/Employment	14.30	61.90	31.82	32.61	40.00	36.13
Peer Relations	2.60	39.29	15.32	23.91	11.40	18.51
Substance Abuse	15.60	34.52	32.39	4.35	5.70	20.28
Leisure/Recreation	9.10	50.00	30.68	28.26	37.10	31.03
Personality/Behavior	13.00	39.29	12.50	19.57	34.30	23.73
Attitude/Orientation	9.10	27.38	18.75	13.04	11.40	15.93

Note: p < .001

Table 8

The Structure of Discriminatory Functions

Areas of Strengths	Discriminant Coefficients		
	Multiple Areas of Strength	Prosocial Attitudes	Prosocial Peers
Family Circumstances/Parenting	0.53	-0.37	-0.40
Education/Employment	0.46	0.05	0.09
Peer Relations	0.39	0.23	0.74
Substance Abuse	0.15	0.79	-0.50
Leisure/Recreation	0.40	0.40	0.30
Personality/Behavior	0.36	-0.31	-0.17
Attitudes/Orientation	0.19	0.30	0.03
Discriminant Function	2.43	0.71	0.18

Table 9

The results of Robust Discriminant Analysis on Strength Areas

Institutions	Centroids on Discriminatory Functions		
	Multiple Areas of Strength	Prosocial Attitudes	Prosocial Peers
Correctional Institution	-0.88	-0.08	-0.08
State Residential Home	1.22	0.66	0.02
Community Residential Home	-0.22	0.27	-0.04
Children's Home	-0.15	-0.32	0.38
Institution for Youth with Multiple Problems	0.32	-0.71	-0.17
F	16.69	31.18	11.06
P	0.00	0.00	0.00

Note: <.001

This research is the first one in the Republic of Croatia that established the risks and needs characteristics of youth through a valid and relevant assessment instrument. For the purpose of this study, YLS/CMI was used when children/youth were already in one of the treatment institutions, but to fully utilize this instrument children/youth should be screened prior to entering the treatment program due to the fact that YLS/CMI provides a linkage between treatment needs of beneficiaries and the development of case plans. The assessment of children/youths should be based on such an instrument rather than on a personal judgment of a few professionals, no matter how competent they may be. The results may be a benefit at both individual and institutional levels. Residential treatment and correctional facilities might benefit from the implementation of a valid risk/need classification system. While the facilities do not choose which offenders they receive, it would be helpful to use the risk assessment to value which specific institution is the most appropriate for an individual. The obtained composite of the risk factors can be used to make security and program level decisions in every specific institution. Regarding treatment and considering risk/need domains of YLS/CMI, a treatment – oriented case plan could place a child/youth into an appropriate treatment service. This is the exact reason why the YLS/CMI is recognized as a potential solution for Croatian juvenile justice and welfare system because of its suitability for many purposes; in decision-making, disposition of treatment, case planning, and juvenile justice system can also be improved.

During the research, several practical and methodological issues arose. To address these, future research should explore whether the treatment programs in the institutions matched the identified area and levels of risk and examine problems in the

assessment procedure especially in the identification of strengths in children and youth.

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Analysis of Guidance and Counseling Program at Thika High School for the Blind, Kenya

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Abstract

The purpose of this study was to analyze the guidance and counseling program at Thika High School for the Blind, the only residential secondary school for students with visual impairments in Kenya. The study examined the content of the existing guidance and counseling program and whether the teacher counselors were adequately trained to handle the youth with visual impairments. The study adopted the fifth stage of Erikson's psychoanalytic theory (1975), "identity versus role confusion" under which adolescents fall. The theory states that at adolescent stage, the youth with visual impairments experience a major crisis due to rejection, negative attitudes, and social stigma from family, peers and society. The study was descriptive and included observations and a survey design. A sample of 22 subjects which comprised of 16 students who were conveniently sampled plus 4 teachers, 1 deputy principal and 1 head of guidance and counseling department who were purposively sampled. Data were collected through questionnaires supplemented by an interview schedule for the deputy principal, unstructured interview schedule for students, and observation checklists for human resources and physical facilities. The study found that there is need to strengthen guidance and counseling services in Thika High School for the Blind through school-based in-service courses, workshops and seminars for teacher counselor.

Introduction

The term "Guidance" is derived from the word guide, which means to show others the way to a place or to direct somebody's behavior (Crowther, 1995). Guidance is synonymous with advice, counseling, direction, help, instructions, leading, teaching and management (Brookes & Gilmour, 2003). According to Mutie and Ndambuki (1999), guidance is expert direction given to young children and adolescents through teaching, direct opinion giving, exemplifying, explaining, advising and instructing. It is a process of helping a person to make the best decision possible about their lives and aiding them in solving problems. UNESCO (2000) proposes that counseling is a learner-oriented process that occurs usually in an interactive relationship. It aims at helping a person learn more about the self and use such understanding to enable the person to become a more effective member of the society. Counseling is, therefore, a process in which the helper expresses care and concern towards the person with a problem. It facilitates personal growth and brings about change through self-knowledge.

Guidance and counseling in Kenyan schools is relatively a new practice yet to be appreciated in schools settings. Dr.

Philomena Ndambuki, a leading psychologist in Kenya and the executive director of the Nairobi-based Neema Counseling and Training Center (NCTC) says that, "Kenyans are yet to understand and appreciate the value of counseling and counselors in the society... the most threatened branch is that of child and adolescent counseling" (Ochami, 2005, p. 6).

The Ministry of Education (MOE) established the first guidance and counseling unit in 1971 which mainly dealt with career guidance on job openings to high school graduates. Then in 1976, when the Gachathi Commission noted that only career guidance was in effect, it recommended that all teachers be trained in basic guidance and counseling and be required to offer the services in their normal duties (Wangai, 2001). But by 1999, the once vibrant guidance and counseling unit was no longer as effective as it used to be. This was because most of the professionally qualified personnel retired from teaching service (Sagini, 1991). The committee recommended that the government should strengthen the unit of guidance and counseling within the MOE head office and in secondary schools a department of guidance and counseling was created. The Teachers' Service Commission (TSC) which is the main employer of teachers' in Kenya was charged with the responsibility of appointing a teacher in each secondary school

to manage the departments of guidance and counseling in schools and he/she was referred to as the teacher-counselor.

There is evidence to suggest that despite much effort shown by the government to put guidance and counseling in place in all secondary schools to help curb youth problems, it appears that not much has been achieved so far. Kenya Education Sector Support Program (KESSP) 2005-2010 indicates that the government of Kenya supports the program of guidance and counseling which was started in 1970's in schools and points out that policy response in this remains weak. Similarly, Ochami (2005) shows that guidance and counseling services in schools are not yet adequately offered to adolescents. Wamocho (2003) points out that the current guidance and counseling program in place has focused more on preparing students for career choices during their final year in secondary school yet it is vital for an individual to know oneself first before engaging in other activities. Thus, it appears that educationists and the government have an urgent problem to solve in providing comprehensive guidance and counseling services to the youth. Wamocho (2003) further argues that the youth with disabilities share similar needs as their non-disabled peers, plus extra needs associated with their disabilities, but the guidance and counseling services in Kenya focuses on students without disabilities only. Based on this observation, she concludes that the youth with disabilities also need guidance and counseling.

Factors that point to a well functioning guidance and counseling department in a school include human and physical resources (Macharia & Ngwiri, 2002). For human and management resources, a comprehensive guidance and counseling program in a school should have a hierarchy of command: Head of Department (HOD), Assistant HOD, Family Units Coordinator, other committee members of guidance and counseling department, other teachers and members of the school. Physical resources should include: a well furnished guidance and counseling room, a private room for counseling, departmental files, case records, schemes of work (programs for each class), record of work, seminars, workshops and reading material (Macharia & Ngwiri, 2002; Wamocho, 2003).

This study was designed to find out how the guidance and counseling department at Thika High School for the Blind, the only special residential secondary school for students with visual impairments in Kenya, had been organized and run. This study adopted a psychoanalytic theory (1975) by Erickson, one of the leading ego psycho-analysts (Pervin & John, 1996) who saw life as a problem-solving process involving an individual. He divided the lifecycle into eight stages of development, each of which consists of a unique developmental task. Every human being is confronted with crises which must be resolved in each of these developmental stages: basic trust versus mistrust, autonomy versus shame and doubt, initiative versus guilt, industry versus inferiority, identity versus role confusion, intimacy versus isolation, generality versus stagnation, and integrity versus despair.

The main interest of this study was the fifth stage of Erickson, identity versus role confusion, under which adolescents fall. It is at this stage that the individual develops a sense of identity or a sense of role confusion. In this identity crisis, the adolescent is trying to understand himself as well as understand his/her place in the society. Those who fail to develop identity, experience a feeling of failure. They don't know who they are or where they are heading in the future (Pervin & John, 1996).

This theory was relevant to this study because the students with visual impairments at Thika High School for the Blind were at the adolescent stage when they may be faced with a major developmental crisis. To these youths identity may pose a lot of problems physically, emotionally, psychologically and health wise because of their disability and the normal turmoil of development posed by the crisis at that stage of adolescence. Neely (1982) notes that the first social experience for any individual originates from family settings. Many children with visual impairments are faced with rejection, negative attitudes and social stigma from family, peers and the society. This may result in negative feelings like loneliness, isolation, withdrawal and failure to adjust and develop a positive self-concept. Similarly, vision plays a critical role in the development of concepts, the understanding of special relations and the use of printed materials. The authors found Erickson's theory to be necessary as they observed that many youths with visual impairments may be faced with identity crises and therefore, provision of guidance and counseling services in school settings becomes necessary at this stage to help them battle through identity crisis and to adjust to having a disability.

This study sought to analyze the guidance and counseling program at Thika High School for the Blind in Kenya by critically examining the content of the existing guidance and counseling program. The major objectives of the study were to (a) identify problems faced by students with visual impairments at Thika High School for the Blind, (b) find out how the guidance and counseling personnel identify youth with specific social personal and academic problems in the school, (c) establish the extent to which the guidance and counseling department helps students with problems, (d) examine what qualifications the teacher counselors have, (e) establish the role played by administrators, teachers and support staff in providing guidance and counseling services in the school, (f) find out how responsive students are to the provision of guidance and counseling services in the school, and (g) identify strategies to improve the guidance and counseling program at the school.

Method

The study was descriptive and included observations and a survey.

Target Population

Thika High School for the Blind has three different classes for each of the four (form one, two, three and four) labeled North (N), South (S), and West (W). This is the targeted student body comprising 71 students. The South stream was reserved for a pilot study. The targeted population included one deputy principal, one head of guidance and counseling department, and ten forms two and three teachers. This added up to a total of 83 students and teachers. Form ones, being too new to the school during the time of this study were left out as

Table 1

Distribution of Students by Gender, Disability and Class

Class	Totally Blind		Low Vision		
	Girls	Boys	Girls	Boys	Total
2N	1	4	9	5	19
2W	2	4	5	8	19
3N	1	5	4	6	16
3W	2	3	2	10	17
Total	6	16	20	29	71

Note: N = North; W = West.

they knew very little about the school. Similarly, form four students were left out as it was an examination class and thus was busy preparing for exams. Table 1 shows the total number of students per the stated classes (form two and three North and West streams-the targeted student body).

Sampling

For the purpose of this study, Thika High School for the Blind students with visual Impairments was purposively selected for this study because it is the only residential high school for students with visual impairments in Kenya. The study used purposive sampling because of low incidence population among the girls who are totally blind in forms two North and three North. From those two classes the girls who were totally blind were purposively sampled. The girls in the West stream and boys from North and western streams were conveniently sampled with equal numbers of low vision and totally blind impairments, one deputy principal from the school, one head of guidance and counseling department in the school and four teachers (two males and two females) from those who had served for more than five years in the school

were purposively sampled to participate in the study giving a total of 22 participants (see Table 2). With the help of the deputy principal, the researcher, through stratified sampling, used class registers to identify equal members of the totally blind students and those with low vision then used convenient sampling to identify the participants while taking care of gender equality.

The questionnaires for teachers without visual impairments were in ordinary print whereas those for the participants with low vision were in bold print and those for participants who were totally blind were in Braille. Each set consisted of both open-ended and closed-ended questions gave the subjects

Table 2

Sample of Students by Gender, Level of Visual Impairment and Class

Class	Totally Blind		Low Vision		
	Girls	Boys	Girls	Boys	Total
2N	1	1	1	1	4
2W	1	1	1	1	4
3N	1	1	1	1	4
3W	1	1	1	1	4
Total	4	4	4	4	16

Note: N = North; W = West.

freedom of expression as no pre-conceived replies were imposed on them while close-ended items enabled the researcher to obtain specific responses for the respondents after being offered a choice of alternative replies. Teachers' questionnaires sought to collect data on teacher's personnel data and on guidance and counseling program in the school. Similarly student's questionnaires, sought to collect students personal data and details of guidance and counseling in the school. Interview schedule sought personal information on guidance program in the school from the deputy principal. Observation checklist, unstructured interview schedule were used by the researcher to facilitate participants observation with the sampled population.

Pilot Study

Pilot study was conducted at Thika High School for the Blind in Form three south using the split half method. Eight (8) student (four boys and four girls were purposively selected) for pilot study. Four teachers were selected to make a total sample of twelve respondents. Completed research instruments were analyzed manually to test the consistency of

the responses. These subjects did not participate in the main study. After piloting the instruments were evaluated in order to verify grammatical and structural errors and adjustments were made accordingly. The eight subjects who participated in the pilot study were not included in the main study.

Data Collection

With permission from the principal and the teacher-counselor, the researcher acted as an assistant teacher-counselor for one month to facilitate participant observation using unstructured interviews. During this same period the researcher, with the help of the teacher-counselor, issued questionnaires to the appropriate groups. The researcher also gathered information using observation checklist and an interview schedule for the deputy principal to collect personal information and on guidance and counseling in the school. Data collection was done after lessons.

Data Analysis

Data analysis was done by use descriptive statistics in three stages: data display and drawing conclusion and verification. According to Scott and Usher (2004), data reduction involved simplifying data into manageable sizes by including what was relevant and excluding irrelevancy. The qualitative data were analyzed by reading and re-reading transcripts, taking notes, highlighting relevant information and breaking it into manageable components. The next step was coding and classifying data in order to make a link between raw data and the theoretical concept. The findings were presented in percentages, tables, pie-charts and graphs. The Statistical Package for Social Sciences (SPSS), computer software was used to analyze data.

Results

Problems Faced by Students at Thika High School for the Blind

The major problems cited by all participants in this study included boy/girl relationships, low self-esteem, denial and withdrawal, lack of fees, pocket money and personal effects, discrimination of students who are totally blind in matters of leadership. A few have been brought up in children's homes having been abandoned by parents or relatives due to their disabilities or are orphans of HIV and AIDS parents.

Identification of Students with Specific Social/Personal and Academic Problems in the School

Information gathered from the teachers showed that students who sought guidance and counseling services were either solicited for by the teacher-counselor or referred by the disciplinary committee, other teachers, students, house mothers/fathers, the principal or deputy principal.

Extent to Which the Guidance and Counseling Department Helps Students with Problems

There was a 100% agreement from all participants that group counseling always took place on Wednesdays after 4.30pm. Responses from all participants revealed that there were various issues discussed which varied from academic achievement, subjects and career choices to social and family relationships, drug use and abuse and personal issues like self esteem.

Qualifications Held by the Teacher- Counselors

Responses from the teachers' revealed that all the teachers were professionally qualified with a B.Ed and three were pursuing M.Ed programs. Only the head of guidance and counseling department had some in-service training in basic skills of guidance and counseling. There was also 100% agreement that there had been no school-based workshops or seminars on guidance and counseling, organized for the members of the school.

Administrators, Teachers and Other Related Staff Support for Guidance and Counseling Services in the School?

Information from all respondents revealed that there was a reasonable amount of support given by the principal, the deputy principal and the rest of the staff in identifying students with problems and referring them to the guidance and counseling department for assistance. Information gathered showed that there was no budget set aside for guidance and counseling. A major problem the teachers encountered was heavy teaching load as per data gathered from teachers, head teacher and teacher counselor indicate that most teachers had between seventeen (17) and nineteen (19) lessons to teach over and above the twelve (12) lessons as recommended by the Ministry of Education (MOE).

Responsiveness of Students to the Provision of Guidance and Counseling in the School

Findings of this study indicated that only 37% of the students sought guidance and counseling services voluntarily while thirty 38% of students said outright that they would not go for help from the teacher-counselor and 25% were not sure and gave different excuses as to why they would not seek help from the teacher-counselor. There was a 100% agreement that group guidance and counseling always took place once a week after classes at 4.30pm, while there was a clear indications from the study that there was no specific program or day set aside for individual guidance and counseling. Fifty-five percent of students did not visit the guidance and counseling office at all throughout the 2006 school year while 19% visited once. Thirteen percent had visited twice while another 13% had visited three times.

Improving Guidance and Counseling Program at the School

Findings of the study revealed that the guidance and counseling office in the school had no proper setting as recommended for a counseling office. There is no reception room and no private room for counseling purposes. There is only one small room with a table, three chairs, a cupboard and shelves. There was only a very minimal budget set aside for guidance and counseling department barely to cater for the guest speakers' transportation. The results revealed that there was lack of privacy and confidentiality as far as the guidance and counseling services were concerned at Thika High School for the Blind.

Discussion

This study revealed that most of the students at Thika High School for Blind were at adolescents stage and were faced with the difficult tasks of discovering self-identity, clarifying their sexual roles, assessing their independence, learning to cope with authority and searching for goals that would give meaning to their lives. They also had to deal with other challenges and those related to their visual impairments. The study further revealed that a few of these students were brought up in children's homes having been abandoned by parents or relatives due to their disabilities or being orphans of the HIV/ AIDS pandemic. All these problems are bound to affect these students physically, psychologically and hence the need for a comprehensive guidance and counseling program.

The fact that group guidance and counseling always took place once a week after classes at 4.30 pm and that there was no specific program or day set aside for individual guidance and counseling negates Mutie and Ndambuki 's (1999) recommendation that guidance and counseling should involve a series of direct contact with the individual so as to offer adequate assistance in changing attitudes and behavior.

Findings of this study revealed lack of privacy and confidentiality. Most students who never went to the teacher-counselor for help expressed fear of shame or being exposed especially when the problem concerned multiple disabilities or unhealthy boy/girl relationships. This may have resulted in the failure of students' to seek guidance and counseling services voluntarily. In line with this observation the study proposes that the principal provides a private room for counseling to enhance privacy and also furnish and equip the guidance and counseling office.

Findings of this study indicated that the guidance and counseling committee in the school was composed of three members only including the HOD, the teacher in charge of the peer counseling club and a male representative. This number is far below what is recommended because according to Mutie and Ndambuki (1999) an effective guidance and counseling department should be comprised of the HOD and five other teachers. There was a general feeling among the respondents that the principal needs to provide a counseling office with proper setting, private room for counseling to enhance privacy

and confidentiality and also to furnish and equip the guidance and counseling office more adequately, provide reading and other resource materials, facilitate in-service courses, workshops and seminars in guidance and counseling.

Teachers in this study indicated that there had been no school-based workshops or seminars on guidance and counseling organized for the members of the school. This shows that the teacher-counselor did not meet the criteria and thus was ill-prepared to handle the challenges of guidance and counseling in the school. According to Brealy and Birchley's (1994) observation a teacher has to undergo training covering 45-69 hours in order to be effective in guidance and counseling. Similarly, Wamocho (2003) posit that guidance and counseling personnel must be selected based on their relevant training, experience and qualifications. Nwoye (1988) states that for a counselor to be effective in counseling persons with disabilities he/she needs to have the spirit of dedication and professional knowledge so as to counsel persons with disability effectively. In view of the above observations and the findings of this study it can be concluded that the teacher-counselor did not meet the criteria to effectively handle the challenges of guidance and counseling.

Recommendations to the MOE, the Principal and the Teachers

Figure 1 shows the recommendations to improve the delivery of guidance and counseling in Thika High School for the Blind and other schools. This study revealed that all members of the school were aware of the guidance and counseling services and that the MOE requires that the department functions. However, due to various constraints efforts to have the services adequately offered were frustrated. Students were in dire need of these services but they did not seek them or receive them to their satisfaction. Therefore, based on the findings of this study the researchers observed that for effective guidance and counseling services to be provided to students at Thika High School for the Blind, the following recommendations be embraced as per the suggestions and be implemented by the Ministry of Education, the school principal and the teacher-counselor.

Conclusion

Although this study was not carried out country wide (research was only conducted in Thika High School for the Blind) our analysis and findings found issues which could be relevant to implementation of guidance and counseling in special secondary schools throughout the country. The study does not provide comprehensive solution to guidance and counseling programs but it creates awareness for

To be implemented by MOE, respective sections	Recommendations
<p>Teacher Training Colleges (TTC)</p> <p>Teachers Service Commission (TSC)</p> <p>Inspectorate Section</p>	<ol style="list-style-type: none"> 1. The guidance and counseling course in the teacher training program should be strengthened. It should be taught as an independent subject rather than a unit in education. In addition, teachers in the department of guidance and counseling should be regularly in-serviced to keep abreast with the latest challenges of guidance and counseling. 2. A course in ethics be designed for the guidance and counseling staff to expose them to the necessity of privacy and confidentiality in guidance and counseling. 3. The in-service course should be affordable to all schools and their advertisement should reach all relevant institutions. 4. The MOE should provide funds to equip the guidance and counseling departments. 5. The ministry of education should ensure that rightfully trained personnel are recruited as guidance and counseling heads of departments. In the case of Thika High School for the Blind, the teacher-counselor who was trained was transferred in 2005 and was not replaced by TSC with another trained one. The current one was appointed by the principal and has only a few basic skills. She should therefore receive comprehensive training in guidance and counseling. 6. The MOE should consider posting adequate staff to schools so that the teacher-counselors are not overworked. 7. The inspectorate should regularly visit schools and guide the guidance and counseling teachers on effective delivery of guidance and counseling services. It was observed that the teacher-counselor was willing, always present and areas to be considered well known but very little was accomplished especially in motivating students to voluntarily seek guidance and counseling services.
Kenya Institute of Education (KIE) Curriculum developer	There is need for KIE to develop more resource materials such as books in both print and Braille, films and tapes to guide the implementation of guidance and counseling for students with visual impairment.
School Principal	<ol style="list-style-type: none"> 1. The guidance and counseling committee members should be increased to meet the needs of the entire student population. 2. The guidance and counseling department should be financially sponsored by the school to attend guidance and counseling in service courses. There should also be school-based seminars and workshops for all stakeholders in the school. 3. Only those teachers who show interest in and are free with students should be recommended to the guidance and counseling committee. 4. Students should be sensitized to take advantage of guidance and counseling services and training of peer-counselors should be emphasized.
Teacher-counselor	The teacher-counselor should be more aggressive in sensitizing students to take advantage of guidance and counseling services and in identifying the students who require these services in the school.

Figure 1. Recommendations to the Ministry of Education

understanding the guidance and counseling programs in special secondary schools and ways of enhancing it. Recommendation is therefore made for a wider area to include primary schools so that an authentic policy statement for all students with visual impairments is put into place for effective implementation of guidance and counseling. Finally a recommendation is made for a similar research to be carried out in schools for students with other disabilities.

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The Learning Program for the Development of Autistic Children (LPDAC): Parents' Perspectives on the Treatment Outcomes

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Abstract

The Learning Program for the Development of Autistic Children (LPDAC) intervention program is a comprehensive cognitive approach designed to treat cognitive deficits in children with autism spectrum disorders (ASD). It has been documented to be one of the most effective instructional programs for autism in South Korea. This program, however, has not been implemented in English-speaking countries. The purpose of this study was to investigate parents' perspectives of the efficacy of this intervention program. Two hundred and six Korean parents participated in this study by responding to a written interview questionnaire. A great number of parents mentioned the intervention program's effects, observed their children's developmental progresses, and believed completion of the intervention would result in positive future outcomes for their children. This study provides a brief description of the LPDAC intervention program.

A considerable body of literature has provided evidence that specific deficits in cognitive function are the primary cause of specific autistic characteristics (Bartak & Rutter, 1973; Bogdashina, 2006; Hermelin & O'Connor 1970; Konstantareas, Oxman, & Webster, 1982; Lotter, 1974; Prior & Sanson, 1979; Rick & Wing, 1975; Rutter, 1974; Schwartz, Sandall, McBride, & Boulware, 2004; Sigman & Ungerer, 1984). These cognitive deficits negatively impact the developmental progression of language, cognition, behavior, emotion, and social relationships and can cause secondary disabilities in these areas (Akshoomoff, 2006; Konstantareas et al., 1982). Thus, a critical point is that if the child with ASD recovers from his or her dysfunctional cognitive ability and can process incoming sensory information normally, the secondary disabilities can be consequentially treated.

The fundamental question, then, is if and how children with ASD can be treated to develop their cognitive ability or overcome dysfunctional cognitive ability. While various interventions and educational programs are beneficial for children with ASD, there has been a lack of scientifically structured instructional programs to treat the cognitive dysfunction of children with ASD (Charman, Howlin, Berry, & Prince, 2004). Among the 108 therapies (Green, Pituch, Itchon, Choi, O'Reilly, & Sigafoos, 2006) currently being implemented for children with ASD, there are no psychological or educational programs aimed at treating the

cognitive dysfunction of children with ASD in the Western countries.

The LPDAC Program, Its Theoretical Framework, and Structure

The Learning Program for the Development of Autistic Children (LPDAC) was developed by the third author, during the course of 20 years of clinical research in treating cognitive dysfunction of children with ASD. It is rooted in the beliefs that cognitive factors are the primary cause of problems associated with autism and the deficits of central cognition of children with ASD can be restored by systematic and structured intervention based on the principle that development of children's cognitive, behavioral, emotional, language, and social functions *progress interdependently and integrally*, each affecting the development of the other (Konstantareas, Oxman, & Webster, 1982). Without development of the cognitive abilities, as demonstrated by typical utilization of language, age-appropriate interpersonal skills in social interactions and relationships, and comprehension through mental imagination and conceptual thinking, children cannot function normally even though specific functional skills may be much improved (Yeo, 2007). LPDAC does not presume autism to be necessarily an incurable, lifelong disorder. Children of all levels of

impairment and all ages are accepted into the LPDAC intervention, though Yeo stresses the advantage of intervention before age 6.

The LPDAC consists of 12 sequenced intervention stages, each stage containing from 3-to-20 intervention activities (total of 168) in which the child's cognitive, language, and social developments are intertwined. Children receive individual, one-on-one, 50-minute intervention sessions three times per week. At Stage 7, a child is evaluated for readiness to benefit from group interventions, and as soon as appropriate, three group-intervention sessions per week are added. The 12 stages are divided into three levels: Readiness, Foundational, and Core Interventions.

The Readiness Intervention (Stages 1-4) focuses on improving attention through *sensory perception* and *person perception*. This activated attention will improve autistic characteristics such as poor eye contact, poor social relationships, self-absorption, obsessive behaviors, attention deficits, self-injury, hyperactivity, and auditory deficits. In this readiness intervention, children with ASD are expected to improve abilities of attention, self-control by oral directions, recognizing others, and auditory perception (Yeo, 2001).

The intervention designed to recover the attention of the child continues through the subsequent intervention stages. Intervention activities gradually move towards the development of cognitive function, heavily focusing on mental processing in the final stages. Foundational Intervention (Stages 5-8) is an initial intervention for cognitive development. It focuses on treating children to improve social interactions through improved perception of objects, peers, and environments. The main content of the intervention is designed to support children learning basic concepts. Children are taught to visually perceive an object as a complete and integrated entity. Children can then perceive an environment as a whole and can make spatial judgments. This expanded visual perception lets children with ASD recognize patterns and structures of objects and environments. *Representation perception* that activates cognitive function will be developed through this foundational intervention (Yeo, 2001).

In Core Intervention (Stages 9-12), children will apply their learned object concepts to social situations and incidents. They will be able to abstract, apply, and utilize concepts of objects through cognition that will be structured and systematized. Children can maintain conversation with others by constructing meanings. Children will work on number application, orally expressing thoughts about their own life, writing journals and diaries, questioning, engaging in collaborative play with peers, explaining stories they have just heard, and comprehending read scenarios. Through expressing and communicating with others, children are able to maintain active interactions with others. They learn to be positive in social behavior and take an active role in human relationships. At the end of the intervention, children with ASD will be able to gradually refine their skills of how to respond to and relate with others (Yeo, 2001).

Group intervention is another unique aspect of this program. It is critical for children to learn to sense and recognize peers around them, communicate with others, share emotion, and socialize with others. Children receive group intervention concurrently with individual intervention. Around stages 7 and 8, children are evaluated to see if they are ready to receive group intervention. The group intervention begins when the child is able to perform mental processing (cognitive process) and draw logical connections in story situations presented by the teacher. Without having the beginning level of mental and social recognition, putting the child in the social situations does not impact developing the child's social cognition. Through group intervention, children have the opportunity to share their emotions, learn about individual differences by comparing themselves to others, learn the feeling of cooperation, engage in competition, help their peers, socialize, and recognize interpersonal relationships.

Rationale for this Study

In South Korea, there are currently nine LPDAC clinic centers which have approximately 300 children enrolled, the majority being diagnosed with ASD. The first and second authors have made three trips to South Korea from July 2007 to July 2008 with a six-month gap between each visit. As a result of these visits they have gained in-depth understanding of the LPDAC through the observation of numerous individual and group intervention sessions (from stage one through stage 12) and directly teaching individuals and groups of children in later stages of intervention to see if they can follow instructions in a manner similar to typical school age children.

The children receiving this intervention exhibited impressive characteristics; they looked very happy and enthusiastic, and had an amazing attention span while watching the instructor's modeling. We had observed the same children's progress at each visit after a six month period. Children in stages 9 through 12 behaved in a manner similar to that of typical children. Through our observations, we recognized a need for an empirical study on the efficacy of this intervention program. However, investigating the efficacy of the intervention program on the therapeutic and developmental progresses of children requires an extended period of time. Therefore, while conducting a longitudinal quantitative research study, written interviews were conducted with the parents of the children in the program as a follow-up to informal oral interviews previously done with groups of parents. The purpose of the written interviews was to collect feedback from a large number of parents and to examine what the parents' perceptions and perspectives were on this intervention program. Five research questions were developed: 1) How did the parents access this intervention program and what motivated them to enroll their children in this program? 2) Did the parents believe the LPDAC program had therapeutic effects? 3) Had the parents observed developmental progress in their children since their children began this intervention? 4) Did the parents believe their

children's progress would approximate the norm upon completing this intervention? 5) Were there any differences in the parents' perceptions and perspectives between children who had different lengths of intervention time, were in different intervention stages, and the age when children began this intervention?

Method

Participants

The participants in this study were 206 out of a possible 245 Korean parents whose children received intervention from the LPDAC clinic centers in South Korea. This represented 84% of the total population in the seven clinic centers in December of 2007 in South Korea. The children had been diagnosed with autism by outside medical clinicians and their diagnoses were confirmed by the centers when they enrolled in the clinic center. Eighty-six percent ($n = 178$) of the children were male while 13% ($n = 26$) were female. Forty-five percent ($n = 93$) of the children received this intervention for less than one year and the rest of children had received one to seven years of this intervention. The children were spread in different intervention stages, but most children were in the stages lower than Stage Eight. Sixty-four percent ($n = 131$) of the children began intervention at preschool or primary elementary ages and the rest of them began at intermediate elementary or junior high ages. It is noteworthy that 97% of the children were being educated in general schools, 60% were in general education classrooms, and 42% were not receiving any additional support. The detailed demographic information is provided in Table 1.

Instruments

The parent's written interview questions were developed by the first two authors to answer five research questions. There were two sections of questions: demographic information and parents' perceptions and perspectives. The demographic section had eight questions related to the children's ages, grade levels, types of schools and classrooms, gender, intervention duration, intervention starting age, and the current intervention stages of their children. The second section of the questionnaire sought to discover six things: 1) How the parents found this intervention program and what motivated them to choose this intervention for their children's treatment, 2) if they believe that this intervention program was effective for their children's treatment, 3) if their children demonstrated any progress since starting this intervention, 4) in what areas their children demonstrated developmental progress if they answered 'yes' to question three, 5) if they believed that their child's progress would approximate the norm upon completing this intervention, and 6) if they had any other comments on this intervention. For questions two, three, and five, responses were coded on a 4-point Likert Scale where 3 represented *strongly believe*, 2 *somewhat believe*, 1

don't believe, and 0 *don't know yet*. For the third question 3 represented *very progressed*, 2 *somewhat progressed*, 1 *didn't progress at all*, 0 *don't know yet*. The first, fourth, and sixth questions were open-ended questions.

The questionnaire was developed in English and translated into Korean by the first two authors. The authors separately translated questions and collaboratively compared each other's translation and agreed on the final Korean version of the questionnaire. The back-translation for the validity and reliability of the translated written interviews were conducted by two Korean-American bilingual colleagues of the authors.

Procedure

Upon receiving permission from the clinic centers and the approval of the Human Subjects committee, a flyer introducing the study and encouraging parents to participate in the written interview was posted on the bulletin boards in the clinic centers. The parents who wished to participate came to the front desk of the clinic center, signed the Informed Parents Consent Form and picked up the Parents' Written Interview Questionnaire. Most parents filled out the form while they were waiting for their children who were attending intervention sessions while some took it home and returned it later. Data collection took three days per center and one of the authors was available at the front desk to assist the parents who had questions.

Data Analysis

In order to investigate the perceptions and perspectives of the parents on the effects of the intervention, mixed quantitative and qualitative methods were used to organize and analyze data from the questionnaire. To answer the five research questions, the collected data were analyzed using three different analysis methods. For research questions one and three, open-ended responses in Korean were analyzed using content analysis (Neuendorf, 2002). First, the main themes of the responses in Korean were extracted through the separate work of the first two authors. The authors discussed and agreed to the final main themes collaboratively. Secondly, the number of responses on the aggregated main themes was computed. Thirdly, the main themes were translated into English by the separate work of the two authors who then agreed on the final English version. The translated English themes were back-translated by the same people who did the back-translation of the interview questions. For research questions two, three, and four, descriptive analysis was employed. The mean scores, frequencies, and percentages were computed. For research question five, a one-way analysis of variance (ANOVA) was utilized. The independent variables were year of intervention durations, nine current intervention stages (stage 10 and 11 were excluded because there was only one child in each), and intervention starting ages. Dependent variables were parents' beliefs in the effects of this intervention, their children's progress, and their beliefs in

Table 1

Demographic Information

Categories	Classification	Number	%
Gender	Male	178	86
	Female	26	13
	No responses	2	
Length of Intervention Time	Less than one year	93	45
	1-2 years	57	28
	2-3 years	28	14
	3-4 years	16	8
	More than 4 years	5	3
	No responses	7	
Current Intervention Stages	Stage one	17	8
	Stage two	17	8
	Stage three	39	19
	Stage four	30	15
	Stage five	22	11
	Stage six	20	10
	Stage seven	27	13
	Stage eight	12	6
	Stage nine	5	2
	No responses	15	7
Therapy Starting Ages	0-4 years old	63	31
	5-7 years old	68	33
	8-10 years old	55	27
	11-13 years old	15	7
	No responses	4	2
Types of School	Regular school	121	69
	Inclusive preschool	43	24
	Special school	3	2
	Others	9	5
Types of Classroom	General ed classroom	71	42
	Gen classroom with assistants	53	31
	Self-contained classroom	23	14

their children's future recovery upon completing the intervention.

Results*Access to the Intervention and Motivation of Having It*

Overall, 186 (90%) out of 206 parents responded to this question. Since 15 parents indicated two reasons, the raw number was computed. Half of the parents ($n = 93$) accessed and decided to access this intervention for their children with ASD on the strong recommendation of the parents whose children were receiving this intervention or from acquaintances who had children with special needs. These parents made up their mind after listening to the existing parent reports on this intervention's effectiveness and their children's progress.

The rest of parents chose this intervention program for their children after studying and learning about it while reading available parent reports on their children's progress ($n=38$), after attending the parents' workshops and seminar or reading Yeo's publications ($n=38$), after developing firm beliefs in the efficacy of the intervention from the organized program structure and well-trained interventionists ($n=29$), on the recommendation of their child's classroom teachers or preschool directors ($n=7$), and after observing children who demonstrated significant progress as a result of the intervention ($n=3$).

Parents' Beliefs in the Intervention Effects

All but six parents ($n=200$) responded to this question. Eighty-two percent of parents indicated that they believed in the therapeutic effectiveness of this intervention (31% ($n=64$) strongly believed; 51% ($n=106$) somewhat believed). Approximately 15% ($n=30$) of parents indicated that they *did not know yet*. None of the parents indicated that they *didn't believe at all*.

The Children's Developmental Progress

Ninety-eight percent ($n=206$) of the parents responded to this question. The majority of these parents (74%, $n=153$) indicated that their children had demonstrated developmental progress since they started this intervention. Of these, 25% ($n=52$) reported that their children had progressed very much and 49% ($n=101$) responded that their children had somewhat progressed. Twenty-three percent ($n=48$) of the parents *did not know yet* and none of the parents indicated that their children *didn't progress at all*.

An open-ended question was provided for the parents to indicate their children's specific areas of progress. Seventy-six percent ($n=156$) of the parents responded to this question. Since many parents provided more than one indicator frequencies were computed. The overall main themes of these specific areas of progress were: (1) attention and eye contact

($n=55$), (2) behavior and emotional progress ($n=53$), (3) language ability ($n=43$), (4) cognitive ability ($n=29$), (5) socialization ($n=20$), (6) response to the directions and requests ($n=17$), (7) person perception ($n=5$), (8) independent and self-help skills ($n=3$), and (9) other skills, such as less sensitivity to the sensory stimuli, upbeat mood, increased academic interests and motivation, etc. ($n=7$). Five parents indicated that they could not specify because their children had been in the clinic center for just a few months.

The Parents' Beliefs on Future Intervention Outcomes

Ninety-eight percent ($n=201$) of the parents responded to this question and 75% ($n=154$) of them believed that their children would progress to the norm (28% ($n=57$) strongly believed; 47% ($n=97$) somewhat believed). Forty-five parents reported that they *did not know yet* and two parents indicated that they *did not believe it at all*.

The Parents' Perceptions

Differences by Different Lengths of Intervention Time. The parents were categorized into four different groups based on their children's intervention lengths: Group One (less than a year), Group Two (one to two years), Group Three (two to three years), and Group Four (more than four years). There was a statistically significant difference in the parents' beliefs in the therapeutic effectiveness among these four groups of parents ($F(4,188) = 3.09, p < .05$). Tukey's *HSD* was used to determine the nature of these differences. This analysis revealed that the Group Two parents demonstrated stronger beliefs ($m = 2.27, sd = .80$) than the Group One parents ($m = 1.83, sd = 1.08$).

There were statistically significant differences in the children's developmental progress among the different intervention durations ($F(4,189) = 9.17, p < .05$). Tukey's *HSD* revealed that the Group Two ($m = 2.14, sd = .81$), Group Three ($m = 2.15, sd = .78$), and Group Four ($m = 2.80, sd = .44$) children demonstrated more progress than the Group One children ($m = 1.32, sd = 1.14$).

There was a statistically significant difference in the parents' beliefs in their children's ability to function like their typical peers upon completing this intervention among parents whose children had received the intervention for different lengths of time ($F(4,189) = 3.41, p < .05$). Tukey's *HSD* revealed that the Group Two parents ($m = 2.11, sd = .89$) had stronger beliefs than any of the other parent groups; the Group Three parents ($m = 1.37, sd = 1.11$) and the Group Four parents ($m = 2.80, sd = .44$) demonstrated stronger beliefs than the Group Three parents ($m = 1.37, sd = 1.11$).

Differences by Current Intervention Stages. The parents were sorted into nine different groups based on their children's current intervention stages; Stages 10 and 11 were not included since only one child was in each stage. There were no statistically significant differences in the parents' beliefs in the therapeutic effectiveness and the children's future

outcomes among groups of parents whose children were in different intervention stages, however there was statistically significant difference in the children's developmental progress among the groups of parents ($F(8,175) = 5.72, p < .05$). Tukey's *HSD* revealed that the children who were in intervention stages five ($m = 2, sd = .75$), six ($m = 2.1, sd = .85$), seven ($m = 2.46, sd = .5$), and nine ($m = 2.8, sd = .44$) demonstrated significantly more progress than the children who were in intervention stage one ($m = .94, sd = 1.12$). The children who were in intervention stages seven ($m = 2.46, sd = .5$) and nine ($m = 2.8, sd = .44$) demonstrated significantly more progress than the children who were in intervention stage three ($m = 1.28, sd = 1.12$). The children who were in intervention stage seven ($m = 2.46, sd = .5$) demonstrated significantly more progress than the children who were in intervention stage four ($m = 1.57, sd = 1.16$).

Differences by Intervention Starting Ages. The parents were sorted into four different groups based on their children's intervention starting ages: Preschool age (2 to 4 years old), primary elementary age (5 to 7 years old), intermediate elementary age (8 to 10 years old), and junior high age (11 to 13 years old). Since only one child was included in a group for 14 or older, this group was excluded from the analysis. There were no statistically significant differences in the parents' beliefs in the therapeutic effectiveness and the children's future recovery among groups of parents whose children were in different age groups. However, there was statistically significant difference in the children's developmental progress among groups of the parents whose children began the intervention in different ages ($F(3,192) = 3.27, p < .05$). Tukey's *HSD* revealed that the parents whose children were preschool ages ($m = 2.10, sd = 1.02$) demonstrated significantly more progress than the parents whose children were ages 8 to 10 years ($m = 1.98, sd = 1.08$). The ANOVA results are provided in Table 2. The mean scores of developmental progress were compared by the length of intervention time, current intervention stages, and intervention starting time to see if there were any progress trends. For the length of intervention time, there were somewhat sharp increases between less than a year and 1-2 years of intervention and 3-4 years and more than 4 years of intervention time. For current intervention stages, sharp increases were seen between intervention stages four and five and between intervention stages eight and nine. For intervention starting ages the older the children began intervention the less the parents observed the developmental progress. However, for the children who began intervention at upper elementary and junior high ages, the mean scores of parents' perceptions were similar. These trends are illustrated in Figures 1, 2, and 3.

Discussion

As mentioned earlier, without conducting a scientific longitudinal study on the efficacy of the intervention program,

Table 2

ANOVA Table: Differences in Parents' Perceptions and Perspectives by the Different Length of Therapy Time, Therapy Stages and Therapy Starting Time.

	SS	df	MS	F	Sig.
By the Different Length of Therapy Time					
<i>Beliefs on the Therapeutic Effects</i>					
Between Groups	10.184	4	2.546	3.092	.017
Within Groups	154.801	188	.823		
Total	164.984	192			
<i>The Children's Developmental Progress</i>					
Between Groups	36.824	4	9.206	9.170	.000
Within Groups	189.737	189	1.004		
Total	226.562	193			
<i>Beliefs on the Future Recovery</i>					
Between Groups	14.974	4	3.744	3.419	.010
Within Groups	206.984	189	1.095		
Total	221.959	193			
By the Different Therapy Stages					
<i>The Children's Developmental Progress</i>					
Between Groups	43.759	8	5.470	5.725	.000
Within Groups	167.192	175	.955		
Total	210.951	183			
By the Different Therapy Starting Ages					
<i>The children's Developmental Progress</i>					
Between groups	11.186	3	3.729	3.276	.022
Within Groups	218.544	192	1.138		
Total	229.730	195			

it is very difficult to conclude the promise of any intervention program. As a preliminary investigation, this study was developed to measure LPDAC's therapeutic effectiveness through the parents' perceptions and perspectives because the parents of the children receiving this intervention are one of the best sources of information about their children.

Overall, the results of this study demonstrated that this intervention had received great support from the parents. If it is considered that a little less than half of the parents' children had received this intervention for less than one year, these are

especially promising results. It is also very impressive that a great majority of the parents (84%) chose to participate in this survey and voiced their opinions about the LPDAC.

First of all, it is interesting to find that there are approximately seven times more boys than girls among participants' children. Even if it cannot be generalized without conducting a study on the prevalence of autism in South Korea, the ratio of male to female is surprisingly greater than that of the United States. In addition, it is noteworthy that the

majority of children attended the general education classrooms with and without personal assistance.

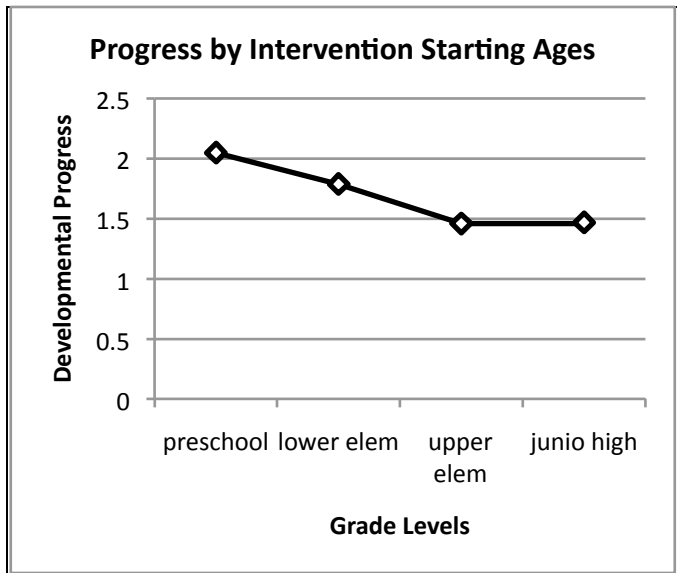


Figure 2. Developmental Progress by the Current Therapy Stages

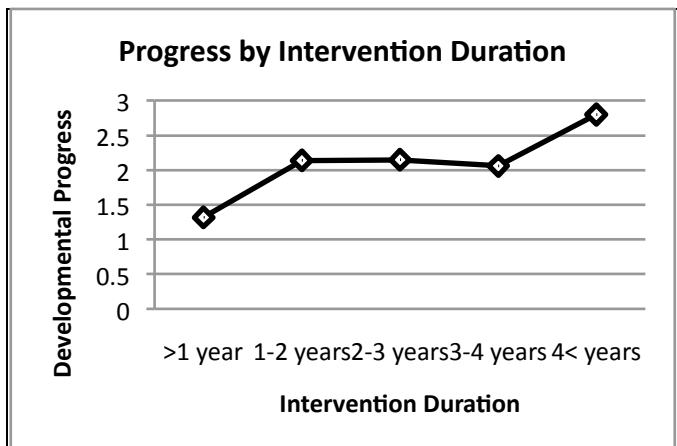


Figure 3. Developmental Progress by the Length of Therapy Time

Almost all intervention programs for students with ASD being practiced in Western countries were available in South Korea. Many parents had compared and contrasted these programs to find an effective one for their children. According to the center’s record, most children with ASD already had several intervention experiences before they began the LPDAC intervention. Thus, many parents had already experienced other intervention programs before being motivated to choose this program for their children based on the perceived efficacy of this program, as attested to by other parents. The highest number of the parents chose this program

for their children’s intervention through recommendation and encouragement from other parents whose children were already receiving this intervention.

It is interesting to find that a majority of the parents believed in the therapeutic effectiveness of this program. A positive point is that the parents whose children had received this intervention for a longer time showed stronger beliefs than the parents whose children had been there for less than one year. It could be interpreted that the longer a child received the intervention, the more apparent was their progress. When comparing the percentage of the parents who did not know its effects yet (15%) to the percentage of the new parents (less than a year (45%)), approximately 30% of children already demonstrated progress with less than a year of intervention. It can be concluded that the length of intervention affected the parents’ positive perceptions on this intervention.

It is impressive that a majority (74%) of the parents observed their children’s developmental progress and no parents confirmed their children’s *lack of progress*. This result could be interpreted to mean that this intervention positively affects the developmental progress of children with ASD. Based on the results of the comparison of the developmental progress of the children with different intervention durations it was observed that the longer period of intervention the children received the more developmental progress they demonstrated. For example, after four years of intervention, the parents observed their child’s progress as being greater/more pronounced than in previous years. It could be the result of this intervention’s efficacy. However, this outcome has to be interpreted with caution because other factors such as maturation may have contributed to the positive outcome.

Comparing mean scores of developmental progress in each intervention stage could help to examine if the children demonstrated different rates of developmental progress in different intervention stages. The parents whose children were in Stages Five and Nine observed more progress in their children than the other parents. This is a very interesting result because Stage Four is the last stage of Readiness Intervention and Stage Eight is the last stage of Foundational Intervention as described in the program explanation. It could be interpreted to mean that the children may show critical progress when completing each readiness and foundational intervention levels.

It is important to examine if intervention starting age affects intervention results since this program emphasizes early intervention. As expected, the younger the children began, the more progress they demonstrated. Based on the parents’ open-ended comments, it was apparent that the children demonstrated progress in the areas each intervention stage targeted. The highest number of parents reported that their children progressed in the abilities of *attention, eye contact, behavior, responses to the directions, requests and person perception*, and *emotional progress* which were targeted in the Readiness Intervention stage. This makes sense because 45% of parents’ children had received this

intervention for less than a year and were likely to be in the Readiness Intervention level. As this intervention focused on the integrative development of language, social, and cognitive abilities, most children generally demonstrated progress in language ability, cognitive ability, and socialization.

The parents may be assured of their children's future progress towards the norm only when they experience progress in the present. It is astounding to find that a great majority of the parents (75%) believed in this result. It could be telling that this belief came from their experiences in this intervention program and their observation of the results of other children in the higher stages. It is interesting to find that the parents whose children had this intervention for two to three years had the lowest beliefs among the four groups and one to two years' parents had stronger beliefs in their children's future results than these parents. However, the parents whose children had this intervention for the longest time strongly believed in their children's therapeutic results. Thus, it is difficult to conclude that the longer their children received the intervention, the more discouraged the parents became about their future recovery. However, since there are not many parents participating in this study whose children received this intervention for more than four years, it is difficult to conclude how intervention duration affected the children's future therapeutic results.

Limitations of this Study

Even though this study yielded positive results on the perceived efficacy of this intervention and interesting facts about the parents' perceptions and perspectives on this intervention program, there are several limitations to this study. First of all, an obvious limitation of this study is that it relied exclusively on parents' self-reported data. It may be preferable to use standardized measurements, such as direct observation, to assess the children. Secondly, even though the overall participants' rate was impressive, there were not similar numbers of participants in each intervention duration and stage groups. Since participation in this study was voluntary, there was no way to engage all parents in the study. Thirdly, this study may not have a highly accurate data analysis due to language interpretation procedures. The questionnaire was developed in English and translated into Korean. In addition, the main themes on parents' open-ended responses were translated from Korean to English. There may have been additional limitations created by a language barrier.

Conclusion and Implications

The prevalence rate of children diagnosed with ASD has drastically increased over the past decade. This increase puts a great deal of importance on developing effective interventions for children diagnosed with ASD. While various interventions and educational programs are beneficial for children with ASD, autism is still defined as a lifelong incurable developmental disability.

Literature has provided evidence that the cognitive deficits cause autistic characteristics and consequential dysfunction in language, cognition, behavior and emotion, and socialization. Therefore, if the cognitive abilities of children with ASD improve and deficits are treated, many of the previously specified characteristics of ASD may be lessened and functional capabilities may more closely approximate the norm.

The LPDAC is a uniquely designed instructional program focusing on treating the cognitive deficits of children with ASD. The curriculum is scientifically structured and systematized based on the developer's clinical study. The parents in the 10th to 12th stages of the LPDAC reported, through informal oral interviews, that their children demonstrated no difference from their peers and were included in the regular educational setting without special education services while maintaining their grades in the above average level. There were not many children in stages 10 through 12 compared to the number in the beginning level stages. According to the intervention teachers and parents, most children do not demonstrate visible differences by this stage and many parents believe in their children's recovery and pull them out of the LPDAC program for other extra academic activities they have been missing, such as English, math, Chinese, piano, etc. However, director Yeo emphasizes the importance of their completion of all 12 stages in order for children to fully recover and develop their cognitive abilities. If all stages are not completed, there may be a possibility of demonstrating limited skills in interpersonal relationships when the children reach their teens. According to our observation of the children, teachers' running records, parents' reports, and the results of this study on parents' perceptions and perspectives LPDAC has become one of the most well respected autism intervention programs in South Korea and promises the typical functioning of the treated children in learning and living environments if they begin intervention before the age of four.

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SUBMISSION GUIDELINES

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PRAXIS

Call for Papers and Submission Guidelines

The PRAXIS section of this journal is intended for readers to be able to immediately apply the methods/strategies described in the articles in their classrooms. These methods/strategies may be new and unique ideas or they can be effective methods/strategies that some teachers have been using and believe that by publishing them, many more teachers could implement them in their classrooms. The articles should be approximately three to six pages and describe in detail a specific teaching strategy or informal assessment method. The articles should include specific instructions on how to develop and implement the methods/strategies. The methods/strategies should require no unique materials for development. These articles are to be submitted following the same submission guidelines and will go through the same review process as all *The Journal of the International Association of Special Education* articles with the exception of including an abstract. (*See submission guidelines*) The format for these articles should include an introduction, step-by-step directions, materials/examples of charts or graphs if needed, conclusions and references.

We encourage you to consider submitting methods/strategies that you have used with students with disabilities and think would be of interest to our readers. Teachers, teacher trainers, professors, students, speech clinicians, psychologists, health care providers, social workers, counselors, family members and those associated with related disciplines are welcome to submit articles for consideration for publication in the PRAXIS section of the journal.

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