Special Education and Rehabilitation: Factors of Development, Different Models of Disability and Some Current Problems

Hannu Savolainen[*]

1. What is special education and rehabilitation?

Special education is a specialised form of education within an educational system that gives support to exceptional students. As traditionally defined, "special education refers to education that is given to students who differ so much physically, mentally, emotionally or socially from the otherwise quite homogenous group of students that special educational measures are needed to meet their educational needs". (Moberg, 1982: 17). The justification for special education is, thus, given from two angles. Firstly, there is an individual who cannot benefit enough from normal educational services. From this it follows that it is not only individual differences that create special educational needs, the incapability of normal schooling to accommodate students with different characteristics also causes the need for such education.

Special education is also connected with overall rehabilitation of exceptional individuals. When looked more closely, rehabilitation can be defined as "goal oriented and time limited process aimed at enabling an impaired person to reach an optimum mental, physical and/or social functional level; thus, providing one with the tools to change one's own life. It can involve measures intended to compensate a loss of function or a functional limitation (for example technical aids) and other measures intended to facilitate social adjustment or readjustment." (United Nations, 1983: 3).

More specifically rehabilitation usually includes the following types services:

. early detection, diagnosis and intervention,

• medical care and treatment,

• training in self-care activities, including mobility, communication and daily living skills,

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.   early detection, diagnosis and intervention,

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with special provisions as required, e.g. for people whith hearing and visual impairment and for those who are mentally retarded,

- provision of technical and mobility aids and other devices;

- specialised education services;

- v o c a t i o n a l rehabilitation services including vocational guidance, vocational training and placement in open or sheltered employment;

  f o l l o w - u p (United Nations 1983:5)

To put it in short, rehabilitation is seen to include different elements like medical, social, vocational and educational services. Education is therefore, an integral and important element of the overall rehabilitation of exceptional persons. To make things easier, special education and rehabilitation could be simply referred to as 'special services'. As the above definitions clearly show, special services are by their nature a joint effort of many academic disciplines and administrative sectors. In order to succeed in the goals set for such services, a good collaboration of the different service sectors, especially those of

educational, medical and social sectors, is needed. Only through good co-operation and follow-up services can the overall well-being of the disabled be enhanced in an optimal way.

2. Factors of development in special services

If the development of special services is looked at in a historical context, one important pattern can be observed. The services seem not to develop directly from 'worse' to 'better'. This notion may sound a bit controversial because we know that the development of science and technology has been very promising, providing ever better solutions for the overall rehabilitation of the disabled. However, actual service provision is also dependent on other things in the society, especially on its overall will to provide these services. A concept relating to the society's will to care for the disabled is the 'ideology of care' as described by Soder (1984). He states that it is 'ideology of care' in any society that best expresses the society's feelings towards its disabled citizens. As a concept, ideology of care refers to all beliefs and attitudes existing at a certain time that deal with questions of what kind and how extensive services should be arranged for the disabled.

The ideology of care is perhaps best seen in the policy papers governing public programs for the disabled. The rationale for the ideology is to be the ethical or moral justification for doing something good for the disabled. But why do we need such a justification? That is mainly because many decisions concerning services for the disabled cannot be based on purely scientific facts. Instead of having only rational scientific justifications, most decisions are based on the prevailing values and beliefs about disability. All in all, in the ideology of care, the scientific knowledge, subjective evaluations and implicit assumptions constitute the background force for any decisions. Thus, although it remains a fact that technical and scientific development concerning disabilities is going forward and producing ever better possibilities to help the disabled to live a normal life, this does not necessarily mean that a society would be willing to utilise all this knowledge for the benefit of the disabled. What is technically possible is not necessarily what a society is willing to do for its disabled citizens.

Also the historical research shows that the development of the ideology of care seems to be connected with overall societal development, especially with the economy. There seems to be a tendency that during times of recession the disabled are seen as a threat to the society whereas in times of rising economy, they are seen as potential reserve in the overall labour force of a nation. But the effect of economy is not usually direct, it is rather brought about by the changing ideology of care. Thus, the relations of all the above aspects of special service development could be reduced to the following figure.
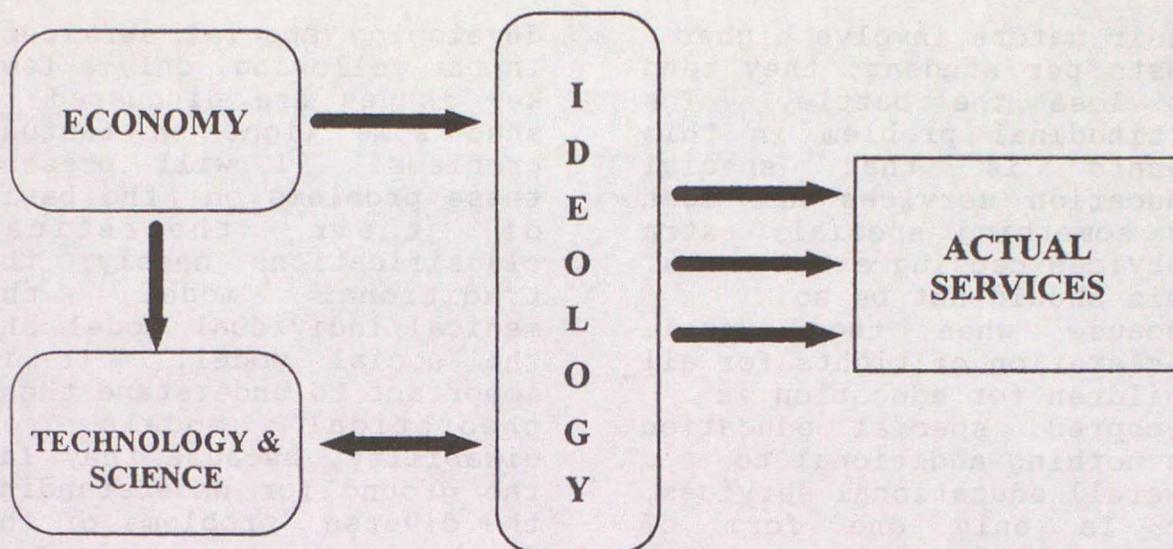
Diagram 1. The role of ideology in special services for disabled people

The practical consequence of this model of development is that an important aspect of special service aims at developing the existing ideology. Even though when economic constraints exist, they should not be used as excuse for not developing special services. Even in a constrained economy, like many of the so called welfare societies of Scandinavia are now facing, the question of providing services is really a question of allocation of funds. If there is enough awareness about disabilities

and acceptance of the disabled as full human beings who have equal human rights, even scarce funds can be allocated in such a way that will guarantee the well-being of the disabled.

However, the problem of special services in this regard is usually in their being 'special'. For example, within the education sector, general education and special education are competing for the same total amount of resources and since special education services by

their nature involve higher costs per student, they tend to lose the battle. The attitudinal problem in this regard is that special education services are seen as something special, extra services causing extra costs. This should not be so, because when the overall declaration of rights for all children for education is accepted, special education is nothing additional to overall educational services; it is only one form of education that is targeted to those children who cannot benefit enough from general education.

The rationale for any educational service must be the right of all children to education from which they can maximally benefit. The right to education is an undeniable aspect of human rights and if it demands higher costs per children for some groups, be they gifted or disabled – this right for additional services should still be taken into account.

3. Some major problems of disability and service provision

Although much of the development has been in the services for the disabled internationally, it remains a fact that there are still very many problems that should be tackled by any programme aiming at developing special services. In the following, only a few key issues are discussed to shed some light on factual problems. I will present these problems on the basis of their theoretical classifications namely; the traditional model, the medical/individual model and the social model. It is important to understand these theoretical models of disability, because they lay the ground for understanding the diverse problems of the disabled in everyday life. Brief definitions of the models are given below.

3.1 Three different models of disability

The **traditional model** is a construct created by religion and culture in a society. According to this, disability is seen as a punishment resulting from ancestral anger or retribution of divine forces. This model is linked to most religions with no exception, (Coleridge 1993).

The **medical** or the individual model largely replaces the traditional model, and is in effect an extension of the former. It has its origin in the biomedical understanding of impairments, according to which disability is usually seen as a lack of competence, due to a dysfunction in an individual's mind and body.

(Reindal 1994:60). Thus, disability is seen as an 'abnormality' which, of course, assumes that it is something different from 'normality'. According to this model, disability needs to be corrected, cured or overcome, (Coleridge 1993).

As the origins or causes of disability are explained in terms of natural science, disability is understood essentially as a problem within an individual, thus, the name individual model. The medical/individual model is currently by far the most common way of understanding disabilities, but it has been lately strongly criticised, especially by the proponents of the following model. According to the **social model**, disability as a phenomenon cannot be reduced to a problem for individuals only. It looks into the origins of disability in a social context in which people with disability are seen as not full humans. Within this line of thinking, two different ways of understanding the social origins of disability have been brought forward lately. These are the social constructivist and the social creationist views. According to Reindal (1995:67) these can be defined as shown in the table below.

Table 1: The social constructivist and social creationst models of disability

	Disability is a result of	An impairment is:
Social constructivism	social meaning that is interrelated within social structures,	a natural biological variety within the species
Social creativism	the practices embedded within society's institutions	a social creation due to social and political factors

Although both models fit into the broad category of the social model of disability, which strongly criticises the prevailing medical model, they differ somewhat in their basic ideas. The proponents of the social constructivist view (e.g. Soder 1989) see that the social environment is the creator of disability, where a special social meaning is attached for the identification and classification of the disabled as 'abnormal'. They believe that population has a normal biological variety of individual characteristics, but for some reason, a social meaning is created through which some characteristics are seen as disability. This (constructivist) view

although quite relativistic, does not want to claim that disabilities would only exist in the 'eye of the beholder' and that one should treat people with disabilities as if they did not have any thing abnormal. It rather wants to point out the negative consequences brought about by the existing social meanings of disability.

The social creationist on the other hand, views disability as a socially created oppression. According to this view, the main problem is located within the institutional practices of society that lead to the oppression of the disabled. It differs from the previous model in that the problem is not seen to be

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located in the minds of people that carry the social meaning of disability. Rather, the social creationists claim that the problem is not in what people think but in what they do, (Oliver 1988). They see that society disables people with impairments with the way it responds to such impairments.

Despite their differences, both the social constructivist and the social creationist models make important contributions to the prevailing medical model in showing the social basis of the creation of disability as a negative state of being. Disability is not a phenomenon that exists only within an individual, it is also a social meaning or stigma of institutions.

3.2 Negative consequences of disability due to the traditional and medical models: some examples

The main problems of disability as understood in the traditional model are the negative attitudes towards disabilities as divine punishment. The practical consequences of this as witnessed by many experts in the field in Ethiopia are the shame it brings to the family of the disabled. Although not much research exists on this as yet, it is common knowledge that disabled people are, for example, often hidden from the neighbourhood. Siblings from disabled family have difficulties in getting married to a non-disabled person. The major social problem arising from these negative attitudes is that it leads to begging and sometimes to being used by others as a source of income. Such negative traditional beliefs are also embedded in the language used in reference to disabled people. Many words referring to a type of disability also carry a connotation of a lesser human being, who in addition to not being able to see or hear, is also intellectually inferior.

The main problem with the medical model is its emphasis on individual deficiencies. The disabled are seen as less humans because they lack some capability. Following from this is the tendency to view disability as a factor that characterises the whole person in question and the failure to see the abilities of such a person. In a recent study on the concepts of disability in Finland (Savolainen 1995), this was the major complaint that the disabled expressed. In their everyday social interactions, the disabled are very often treated and spoken to as if they were children or could not use their remaining senses. One physically disabled person states "the fact that I cannot walk does not mean that I cannot see, hear and understand."

This tendency of not being able to see the disabled as full humans leads into difficulties in social interactions basically, because the non-disabled do not know how to react to the

disabled. In communication situations, there is a tendency by the non-disabled to take charge of the discussion. They easily feel that they are responsible for leading the discussion and this often leads into communication that underestimates the disabled person and this can provoke a hostile response, (Savolainen 1995). One can often hear the non-disabled saying that the disabled are aggressive. This is due to the problem of not understanding such people. The non-disabled person may have a sincere wish to help, but may show this in a way that is humiliating to the disabled, thus creating an aggressive response. Still on both sides, there is a positive motive behind the unsuccessful interaction: the non-disabled person's wish to help and the disabled person's wish to keep her or his integrity. A way out from this is increased awareness and better understanding of disability, that goes beyond the medical model.

One paradox in the non-disabled society's relation with the disabled is the balance between rejection and over-protection. Concerning practical life situations, the disabled are very often rejected and left outside normal social interactions. But on the other hand, people can sometimes do this because they want to protect the disabled. One example of this overprotection is the common phenomenon that if a disabled person tries to form

a relationship with a non-disabled, it may be assumed that the latter is trying to use the disabled financially or otherwise (Savolainen 1995). This assumption is caused, I assume, by the initial belief that disabled persons are not full human beings, with own intentions, will and capability to run their lives as they wish: and when they are seen as inferior being, the logical conclusion is that it must be the other person who takes the initiative for the benefit of the disabled. We, the non-disabled, automatically tend to think and act on behalf of the disabled ones even when it is not necessary.

To state this paradox in general terms, the disabled are sometimes allowed to participate in social activities and services as beneficiaries and they should take whatever the charitable people my give them. They are not allowed to make their own choices, accept or deny any offer or services and decide to take their own initiatives. In a way the medical model of disability considers the disabled as receivers and the non-disabled as users of services, (Rimmerman 1986).

At a more general level of understanding the causes of disability, there is a danger that the idea of the medical model can be used as an extension of the traditional model of disability. In the traditional model, disability is seen as a form of punishment from ancestors'

evil deeds. From discussions with people working in Ethiopia, I have noticed an overemphasis on the hereditary causes of disability. This is actually only a translation of the traditional model into the language of modern science, where chromosomes take the place of divine punishment. In both cases, however, disability is rooted in the family history of the disabled, thus leading to discrimination. This is not to say that there would not be any hereditary causes of disability; there surely are, but their proportion to other causes, in Ethiopia, like anywhere else, is rather small.

The negative consequence of the medical model for the provision of services is what could be called 'institutional mentality'. By this is meant that disabled persons must be given services in institutions, that are often segregated from the society. The traditional idea of forming big institutions is no longer dominating the field but the mentality still seems to persist. If services are available, the disabled are often seen as the lucky receivers and usually do not have any say in the planning or decisions about the scope and target of intervention. Instead, most decisions are made by experts, who are given the responsibility by institutions. This leads to the institutionalisation of the disabled, that is, they become deprived of the normal will and right to make decisions by themselves concerning the way they should lead their lives. This strong ethical dilemma can remain hidden in the institutional mentality as it is believed that society is doing good for the disabled and that it is the disabled person's duty to accept whatever this entails because it is based on a sound professional judgement. Actually, in today's world, it is not the buildings, as it is the mentality that institutionalizes the disabled, (Coleridge 1993).

3.3 Some ways out of the problems

There are no easy ways out of the problems mentioned above; no single solution can be found as a panacea for all problems. However, an important step toward this is the recognition of the different models of disability and the problems connected with them. I also strongly believe that the ideas proposed by the social model of disability, be it the social constructivist or the social creationist view, are important in opening new ways of understanding the origin of the problems faced by the disabled. Activities aiming at promoting a better life for the disabled must include societal actions to change the discriminating social meanings and institutions that partially contribute to the problems.

In any activity, the most important goal is to listen

to the voices of the disabled. Their experiences of the negative attitudes and discriminations in their everyday lives is the primary information that is needed in gaining a full understanding of the problem. This notion is actually a due reminder for academic research on disabilities. Very often the actual opinion of the disabled is not asked for, rather parents or experts are referred to. In some cases, interviewing disabled persons can be difficult and may require special arrangements such as sign-language, interpreter, video interview, Braille questionnaire etc. but this should not be an obstacle, but a challenge for developing research methods.

Regarding the problem of institutional mentality, more community based approaches seem to be important steps. The real change that should come about is not in the form of service provision, but rather in the change of attitudes. Even many trouts of community based approaches have fallen into the same trap of institutional mentality, (Coleridge 1993). What is important is that the services used by the disabled should not be segregating instead, any service should be aimed at making it possible for the disabled to lead as normal lives as possible. In some cases existing institutional frameworks can serve for this

purpose, but in many cases - especially in countries with wide-spread rural communities like Ethiopia - less centralised community based approaches are needed for wider coverage of services.

But if real change is to come, the disabled themselves and their families must have a say, as to how they want the society to help them in this process. The disabled persons must not remain mere **receivers** of special services following clinical diagnosis and specialised decisions of experts.

Finally, any of these improvements necessitate a positive development in the 'ideology of care'. As stated before, it is in this ideology that a society expresses its will to accept the disabled people. The economic constraints will always exist in every country as a possible excuse for the unsatisfactory social policy and decisions making. Never will there be enough resources to guarantee positive development if an ideological background is missing. To quote coleridge (1993, 211-212), the bottom line in special services is that "the 'problem' of disability is created by an able-bodied and disabling world that refuses to accept disabled people on their own terms. Prejudice and discrimination are the result. Action has to start with the disabled people."

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FACTS AND FIGURES

General Education: Summary Table, 1986 E.C./1993-94
Enrolment

Level	Boys	Girls	Total	% of Girls
Kindergarten	32928	33158	66086	50.2
Primary	1410561	873073	2283634	38.2
Junior Secondary	191721	165707	357428	46.4
Senior Secondary	195625	161569	357194	45.2

Teachers:

Level	Male	Female	Total	% of Female
Kindergarten	41	1597	1638	97.5
Primary	55574	20162	75736	26.6
Junior Secondary	9450	1161	10611	10.9
Senior Secondary	10018	969	10987	8.8

Schools:

Level	Government	Non-Government	Total	% of Non-Government
Primary	8196	478	8674	5.5
Junior Secondary	987	180	1167	15.4
Senior Secondary	277	26	303	8.6

Ratio:

Level	Pupil/Teacher	Pupil/School
Kindergarten	40	101
Primary	30	263
Junior Secondary	34	306
Senior Secondary	33	1179

Level:

	Boys	Girls	Total	% of School Age Population		
				Boys	Girls	Total
Kindergarten	1.1	1.2	1.2	10.5	10.2	10.4
Primary	27.5	18.0	22.9	18.6	17.7	18.2
Junior	12.9	12.0	12.5	5.4	5.0	5.2
Secondary	7.7	6.9	7.3	9.3	8.6	8.9
Senior Secondary						

Total Population	27577500	27360600	549

Population source:

1. Statistical Bulletin 101,1984 e.c.
   Central Statistical Authority
2. Single age breakdown by Sprague Multiplier
   Ministry of Education

The Institute of Educational Research launched a National Survey on Disability from January 12-26, 1995

Declaring the Date of the National Base-line Survey

The national base-line survey covered 5085 selected sample households in almost all the regions of the country. The survey involved 18 centre coordinators, 96 supervisors and 144 enumerators. This was done in collaboration with the Ministry of Education with funds from Finnish International Development Agency (FINNIDA).
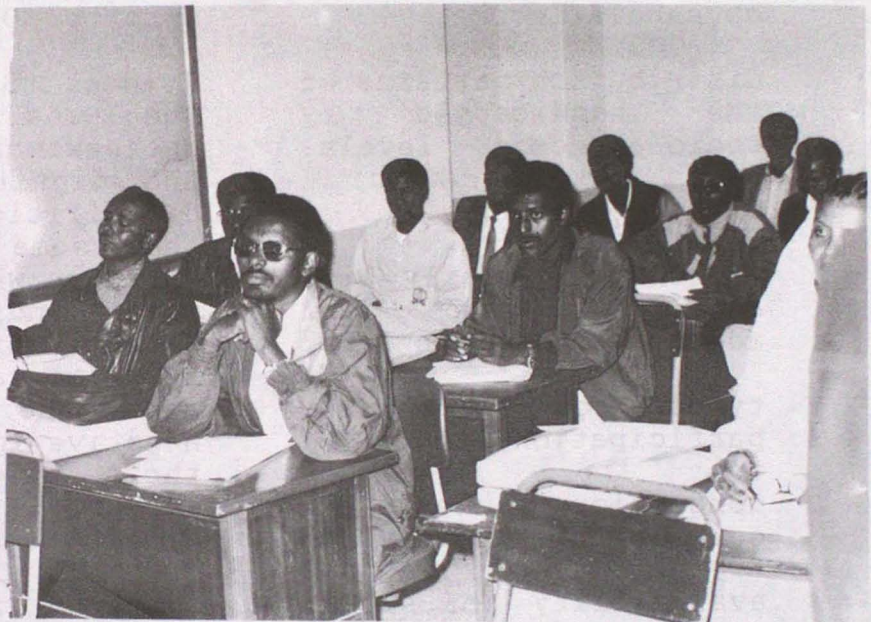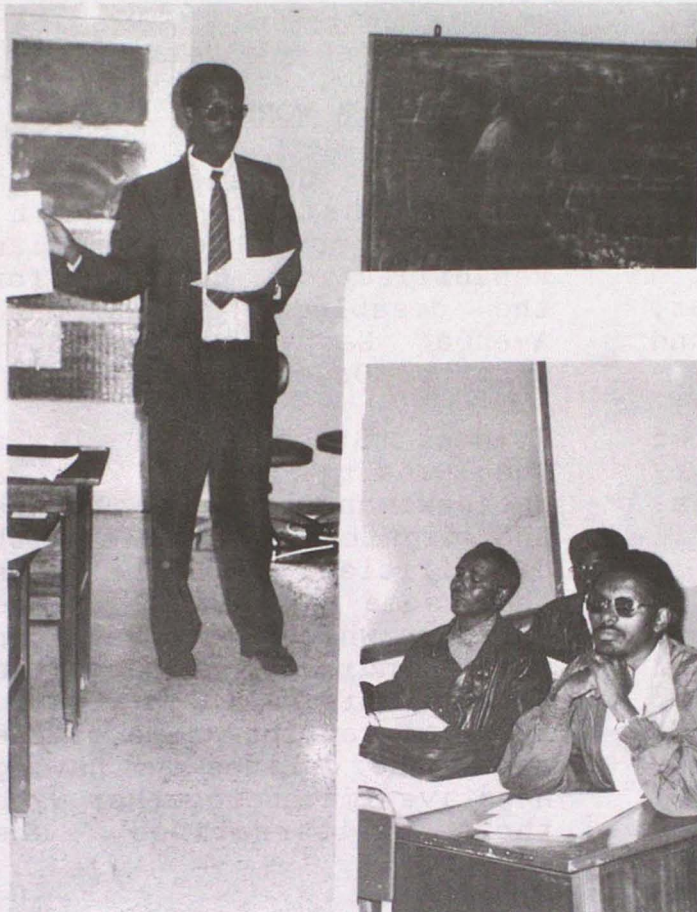
Training Session for Centre Coordinators and Field Supervisors

The survey, which is the first of its kind has helped to collect both qualitative and quantitative data to determine the prevalence and magnitude of disabilities, the type and degree of impairments, the priority areas and to establish sets of activities leading to programme development. It also helps to secure information about the attitude of the public towards persons with disabilities and the self perception of the disabled themselves.

The specific objectives of the survey includes the investigation of differential

factors related to the handicapped with focus on:

distribution patterns of persons with disabilities by region, zone, woreda and household;

distribution patterns of persons with disabilities by gender, age, education and household income;

distribution patterns of the handicapped by socio-economic levels, and socio-cultural characteristics;

patterns of family life and degrees of adjustment to such life;

types of community participation;

conception of causes and cures of disabilities;

availability of social services such as shelters and food, employment opportunities, inter-family support systems;

Isolation and integration patterns by age, gender and other socio-cultural variables and

identification of early intervention of modalities.

The empirical data is being processed and the results will be public in two or three months.

WHAT'S IN A WORD

(This is an excerpt from Rehabilitation digest, published by the Canadian Rehabilitation Council for the disabled, 45 Sheppard Avenue East, Suite 801, Toronto, Ontario M2N 5W9.)

Frances Strong, who is a wheel-chair user, is a spokeswoman for the rights and dignity of people with disabilities. She believes that some words can create barriers which are more often more handicapping than the actual disability itself. Below we reprint some of the words she defines as having negative images together with those alternatives she suggested.

*CRIPPLE, CRIPLED – The image conveyed is of a twisted, deformed, unattractive, useless body. The effect is strong stigmatization and total, all-encompassing inferiority.

Instead use 'disabled', disability. Person with a disability is better than a disabled person because it puts the person first and the disability second.

*PATIENT – Being disabled is not the same as being ill. Omit the word 'patient' except in reference to doctor or hospital situations, or when someone is actually ill.

*VICTIM - People do not like to be perceived as victims for the rest of their lives, long after the victimization has occurred. Instead, say a person who has had a spinal cord injury, polio, stroke, etc.

*RETARDED - This word has become stigmatizing and is offensive to people who bear the label. Instead, say person who has a mental disability.

*DEAF AND DUMB - Is as bad as it sounds. Inability to hear or speak does not indicate less intelligence. Instead, say hearing disability or impairment, unable to speak, partial or total hearing loss.

*RESTRICTED TO, CONFINED TO A WHEELCHAIR, CRUTCHES - Most people who use wheel-chairs, and other mobility devices, do not regard them as confining. Instead, they are viewed as liberating, as a means of getting around. Instead, say one uses a wheel-chair or crutches, or walks with crutches.

*HEALTHY - When used to contrast with disabled, healthy implies that a person with disability is unhealthy. Many disabled people have excellent health. Instead, say able-bodied, able to walk, see, hear, etc, people who are not disabled.

*NORMAL - When used as the opposite of disabled, implies the a disabled person is abnormal. This is very demeaning; instead say people who aren't disabled, etc.

*AFFLICTED WITH, SUFFERING FROM - Most people with disabilities don't view themselves as afflicted or suffering all the time. Instead, say a person who has (name the disability). What do readers think about these words? Do you have words you don't like to be used? Let us hear your views so that we can share them.