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ABSTRACT

The objectives for this advanced study institute were to define learning disabilities so that the definition would be useful for national application; to define interrelated problems; and to establish the extent training centers and university training programs could be augmented and oriented to meet the urgent demands of the nation in these areas of special education. Speeches and discussions delineate changes in outlooks for professional training; estimate the incidence of learning disability and the problem of interrelated areas. The report of the proceedings program is enriched by the concluding discussions. (ON)

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Transcript of Proceedings

CONFERENCE

LEARNING DISABILITIES AND INTERRELATED HANDICAPS

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1 **C O N F E R E N C E**

2 **LEARNING DISABILITIES AND INTERRELATED HANDICAPS**

3 - - -

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6 - - -

7 Parkes Hall
Northwestern University
8 Evanston, Illinois

9 Tuesday, August 8, 1967

10 The Conference was convened at 9:05 a.m., Dr. Helmer
11 R. Myklebust, Director, Institute for Language Disorders,
12 Northwestern University, Chairman, presiding.

13 PRESENT:

14 DR. HELMER R. MYKLEBUST (Chairman)
Director, Institute for Language Disorders,
15 Northwestern University

16 DR. SAMUEL A. KIRK, Director
Institute for Research on Exceptional Children
17 University of Illinois

18 DR. CORRINE E. KASS, Coordinator
Interrelated Areas and Learning Disorders
19 Bureau of Handicapped Children,
Department of Health, Education and Welfare
20 Office of Education, Washington, D.C.

21 DR. ERWIN O. SMIGEL, Head, Department of Sociology
Graduate School of Arts and Science
22 New York University

23 DR. JAMES H. McBURNEY, Dean,
School of Speech
24 Northwestern University

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1 PRESENT (Continued):

2 DR. SAMUEL C. ASHCROFT, Chairman
Department of Special Education
3 George Peabody College

4 DR. FRANCIS X. BLAIR, Director of Professional Training,
School for Research on Language Disorders
5 University of Wisconsin-Milwaukee

6 DR. JAMES C. CHALFANT,
Assistant Professor of Special Education
7 University of Illinois

8 DR. EVELYN DENO, Professor
Educational Psychology
9 Department of Special Education
University of Minnesota

10

DR. LOUIS A. FLIEGLER, Chairman
11 Department of Special Education
Kent State University

12

DR. PHILIP H. HATLEN, Associate Professor
13 Department of Special Education
San Francisco State College

14

DR. HAROLD HELLER, Program Specialist
15 Education of the Mentally Retarded
Division of Training Programs
16 U.S. Office of Education

17 DR. FRANK M. HEWETT, Chairman
Area of Special Education
18 The Neuropsychiatric Institute
UCLA Center for the Health Sciences

19

DR. ROBERT H. RIDGWAY, Associate Dean
20 School of Education
University of Kansas

21

DR. HARRIE M. SELZNICK, Director
22 Division of Special Education
Baltimore City Public Schools

23

MISS JOSEPHINE TAYLOR
24 Director of Education Services
New Jersey Commission for the Blind

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25

DR. WILLIAM G. WOLFE, Chairman
Department of Special Education
University of Texas

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1 **P R O C E E D I N G S**

2 DR. MYKLEBUST: It is my pleasure to call you to
3 order this morning. I trust you all had a little rest last
4 night.

5 We will get on with the first part of our program. I
6 am very happy that Dean McBurney, Dean, School of Speech, cou
7 come over for just a few minutes to meet you people and to gi
8 you a few remarks.

9 DEAN McBURNEY: Thanks, Mike.

10 I am scheduled to bid you welcome. I imagine this
11 has already been accomplished since I understand you met last
12 night.

13 Be that as it may, we are delighted to have you wit
14 us. I am sure that Dr. Myklebust and his associates will be
15 very gracious and competent hosts.

16 They have developed a program in learning disabilit
17 here with us which I think has accomplished a number of thing
18 for the University.

19 I think it has -- and I trust Mike will agree with
20 this -- served to integrate and unify many things that we have
21 been doing over the years in very helpful ways, and I think
22 too it has provided a conceptual framework or platform for
23 projecting new areas of study, new research endeavors.

24 Now, I understand that one of the primary purposes
25 of your meeting here today and tomorrow is to define some of

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1 these concepts with which we and you have been dealing. To
2 me, this should be a very useful undertaking, and I wish you
3 all success in this enterprise.
4 Now, ladies and gentlemen, I have a class waiting
5 me -- I hope -- so, if you will excuse me, I will turn you
6 over to Dr. Myklebust, and I am sure you will be in very goo
7 hands.
8 Good luck with your meeting. Thank you.
9 DR. MYKLEBUST: Now, I know you are a little con-
10 cerned about this room being warm yet this morning.
11 (Remarks off the record concerning arrangements.)
12 DR. MYKLEBUST: Unless you have questions or commen
13 this morning, if everybody is all set to go on, then it is my
14 pleasure to introduce Dr. Smigel.
15 We are very pleased Erin Smigel would take the time
16 to come out here to be with us. Now, his field is sociology.
17 He is head of the department at NYU.
18 As I am sure most of you know, he has been interest
19 for some time in professionalism -- that is, who is the pro-
20 fessional and how the world of professional training expecial
21 is changing.
22 Now, it is for this reason and other reasons that w
23 very much wanted him here this morning.
24 Dr. Smigel, you can remain seated if you care to,
25 whichever you prefer, and we are happy for you to go ahead,

1 please.

2 DR. SMIGEL: Last night as I was thinking about wha[t]
3 I would say this morning, I decided that I knew you well enou[gh]
4 that I didn't have to tell a standard bad joke. But it turne[d]
5 out the bad joke I decided not to tell came to be true -- and
6 that is that the preliminary notes that I wrote last night I
7 lost.

8 And I was going to say to you, "On the way to the
9 forum I lost my notes." (Laughter) And I thought that was a
10 bad joke. And it turned out it was true.

11 But what I was going to say was that I was very im-
12 pressed with the work you are doing. It seems like you are a[ll]
13 on great adventures.

14 In this group they don't seem to be as separate as
15 they did in a conference I attended in Maryland, which some o[f]
16 you also attended, but it does bring up the problem I want to
17 talk about today.

18 That is, if you in this group and in others like yo[u]
19 want to form professional association and want to be considere[d]
20 professionals in terms of the kind of work you are doing, not
21 in terms of your job as a teacher or in terms of some other
22 standard, then what does it mean to be a professional?

23 Suddenly there has been a lot of interest in pro-
24 fessions, and there has been an interest in occupations. The
25 interest in occupations seems to have started during the

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1 depression when work became important because of the lack of i
2 Some people decided to think what were they going to
3 do, how were they going to get out of it, and this brought it
4 to sort of public attention.
5 Then, during the War, the interest increased, becaus
6 the Army was classifying people by occupations, and some were
7 staying out, and some were getting better jobs for being in.
8 And so we have this tremendous increase in interest
9 in professions, in occupations.
10 However, during these years the occupations have be
11 in a process of change. What was a physician 30 years ago is
12 not a physician today. Certainly physics 30 years ago is not
13 physics today. I think we can go down the line of most major
14 professions and find that they have changed radically.
15 What I would like to do today is discuss some of th
16 difficulties in determining what a profession is. It seems t
17 be a simple word, but it really isn't a simple word. There a
18 a number of definitions. There are lay definitions which are
19 incorrect or irrelevant as far as we are concerned.
20 One such definition is that the professions are
21 synonymous with occupations. In other words, everybody says
22 "in my profession." The cab-driver says "In my profession I
23 have to do such and such."
24 Then we have professional versus amateur -- so the
25 professional baseball team versus the college baseball team.

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1 And we don't mean "professional" that way, but these words are
2 often used that way. And, unfortunately, they mix us up.
3 Then we have the use of the word "professional" as
4 invidious and derogatory, and they talked about the leader of
5 the band saying, "Now, Professor, one, two." And this, of
6 course, not what we mean.
7 However, even though these definitions are not the
8 ones we are going to use, they become important because if
9 people use them and see them a certain way and see professions
10 in a certain way and then react to the word in a certain way,
11 it has significance for us all along the line.
12 We don't really know very much about what degree of
13 uniformity there is in lay people's concept of what a profes-
14 sion is.
15 I did have a student who was doing a study of this,
16 and I saw the results, but I haven't seen the final material.
17 What he did was to take a small town and give a series of
18 sentences that equal the definition of profession. He gave
19 it to both professional people and lay people to see if they
20 had different concepts of professions.
21 He gave more than a series of what is a profession.
22 He also gave occupations, mixing it in, so they had to pick
23 out what factors made up a profession.
24 Well, in addition to the lay conceptions, we have
25 conceptions of the professions current among the established

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professions. In other words, what do professionals think professionals are?

Now, this becomes important to know something about, because it has to do with referrals, and it also has to do with recruitment and status. In other words, if a psychiatrist thinks that something is a profession, he may refer work to that job which he considers a profession. But if he has a low opinion of that occupation, he doesn't refer work.

There have been a lot of studies in terms of lay people about what they know about different occupations, one study by Merton and Hatt. Merton you may have heard of. He was head of the department at Columbia, and he has worked in this field a long time.

Merton found that there were only three professions that everybody except 1 per cent of the country knew something about -- whether it was eaxct or not. Those were medicine, law, and the ministry.

After that, as you went down the list, they knew less and less, until it became very vague, especially in the physical sciences.

Sociology, for example, received a fairly high rating in a list of 90 occupations in terms of status. When they asked the people what they thought sociology was, they really didn't know. So they were voting on whatever their image was in terms of a status.

Then, it becomes important to have an identity both for lay people and for professional people.

In a study in Louisville some time ago they asked physicians, lawyers, ministers, school-teachers under what circumstances, if at all, would they send people to a psychiatrist. And physicians, even though psychiatrists are physicians, were the least likely at that point in history to send patients to psychiatrists.

Therefore, if the psychiatrist really wanted referrals -- which they don't need anymore -- if they really wanted the referral system -- and where the best referral system was from other physicians -- they'd have to do something about changing their image.

Another concept is the concept of administrators or legislators. This becomes very important because there are a lot of jobs that come from the Federal Government, and these jobs are labeled. And if they are labeled sociology, the sociologist gets it. If they are labeled statistics, for example, sociology may be the statistician, and it may be something else.

And in new occupations, new professions, one of the things that I suppose a new profession needs is recognition by the Federal Government for grants, for monies. Who do you apply to? How do you know what to apply to? How do you know what jobs exist if it doesn't have your title?

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1 So the American Sociological Society moved down to
2 Washington, where they already found political scientists and
3 I think the psychologists and I don't know how many other dis-
4 ciplines had moved.
5 So I think a lot of professional groups are in Wash-
6 ington to try to influence the Government in determining whethe
7 they are a professional, whether their names should be listed
8 in the list of jobs.
9 All right. Now, then, we come to the researchers'
10 and sociologists' picture of "profession." And there are a
11 number of different definitions.
12 In fact, all cultures name and classify occupations,
13 and these classifications imply prestige, high, low, et cetera.
14 In the English-speaking world the term "profession"
15 is now used for certain occupations which enjoy a great deal
16 of prestige and which give some esoteric services often based
17 on science.
18 So, first, we have the idea that all professions
19 are occupations but all occupations are not professions.
20 Now, occupations which are professions apply some
21 esoteric scale plus the motto that "the taker believe in us,"
22 as against what business people say -- "let the buyer beware."
23 In other words, the professional man has to have the
24 confidence of his client. The businessman probably should.
25 But we don't trust him as much as we trust our physician.

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Even if we are doubtful about the physician, when we go to a physician, we may go to another one, but we don't go to a series of them usually.

If we buy a used car, after ruining our shoes incorrectly kicking the wheel, we keep going to one place after another looking for that used car -- and always afraid that we are getting cheated.

So let the buyer beware is still true in business, though less so. And let the taker believe in us is still true in the professions, but maybe less so.

One of the places that it is still true is among the elite. An elite lawyer will not let his client tell him what to do. He will just say, "If you don't want me, I'm not going to play."

It turns out from my sources in medicine that the solo practitioner feels all sorts of pressure from the patient: "Okay, Doc, will you give me a shot." Pennicillin he means. You have to use "shot" now carefully. "Will you give me a shot?" And they feel badly if they don't get this shot.

Or, "Write out an excuse for my son, even though he wasn't sick" -- or for the insurance companies. And all sorts of things that they don't seem to want to do but feel they have to do to keep their clients.

Elites in the profession won't do that.

All right. Now, another thing that happens to us is

that we are still using the 19th century model of professions. That is, we still use medicine and law as our models. We still use the solo practitioner as the model. We still use what we used to call the free professions.

That is, a profession is conceived as an esoteric art practiced by a closed group of people, each by himself, eac having relations to a number of separate clients, and each collecting his own fees.

This was the 19th century image, and this is what some of the canons of ethics are still based on, even though we live in an entirely different world now.

You can't practice by yourself anymore. At least you can't practice properly by yourself anymore.

So that lawyers in New York City who claim to be solo lawyers have built a network, an informal network, of relationships with other solo lawyers who start getting expertise in various fields. They are not as specialized as the law firms that I studied, and I will talk to you about that in a second, because these become the model of what the new professions are becoming. But they do become specialized.

Now, in Bloomington, Indiana, where I lived for eight years and did a little study of lawyers there -- lawyers happen to be my field so this will be where my examples mostly come from -- they did have 28 lawyers there. Most of them were solo, but most of them were doing very simple kinds of work.

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A lot of them were bill-collecting, and this is best done by yourself with a "strong arm" man.

A lot of them were doing some minor criminal work, and only two or three had some sort of firm.

Now, whether they had this network yet or not I don' know, but eventually they will. Since there is such a prolife ation of knowledge and since this is growing at such a fast rate in all areas in this country, all areas that we think about in terms of the profession, you can't know everything. You just can't know everything anymore.

In sociology, for example, you go to an industrial sociologist with a question on the family, and he says, "That' not my field." It's hard enough for him now, with all the books on sociology and journals, to keep up with industrial sociology.

All right. So, now, this is part of what is happening. You can't practice anymore by yourself.

And the lawyers in Wall Street -- and by "Wall Street" I mean LaSalle Street here, any business street -- th lawyers in Wall Street don't practice by themselves. And part of their strength lies in the fact that they specialize.

In my study, the largest firm had 160, which is the number I have here, but by the time I looked it up again it was 167 lawyers. Now, imagine 167 lawyers practicing together. This is a new world.

1 Underneath them there are 200 other people, clerks,
2 filers, typers, investigators, and so on. All under that.
3 There are 400 people sitting up in these buildings on LaSalle
4 Street.

5 The largest one here when I was here -- and I studi
6 four firms in Chicago -- had 100 lawyers in it. And in Hous-
7 ton there are three or four of them now with this number.

8 So it is so all over the country. San Francisco ma
9 have five like that, or more now.

10 I wrote to each big city over 100,000 and asked the
11 the numbers of their firms.

12 All right. Now, I studied 20 of these large firms
13 in New York, and I wanted to see what happens to professional
14 people when they have to work together, when they have to wor
15 as a team.

16 Because one of the fears that people have, that pro
17 fessional people have, is that if they work as a team they lo
18 part of their autonomy, part of their independence, which is
19 what professional people want.

20 So, how can you have both? How can you work to-
21 gether and still be autonomous? How can you be a team and
22 be independent? How can you be professional in a real sense
23 of the word, in a major sense of the word?

24 Or in medicine, if we want to get away from the la

25 for a minute, there isn't a doctor in a big city who can prac

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1 without a hospital. You just can't practice without a hospital.
2 Some may because they can't get in, but you really can't prac-
3 tice medicine anymore without a hospital, without the labora-
4 tories, without all the other occupations, semi-professional
5 and professional occupations, that go with medicine today.
6 Medicine is no longer the doctor and serfs under-
7 neath him, though the doctor may still think that is what it is.
8 Medicine is not practiced that way.
9 And this is going to increase -- that is, the de-
10 pendence of the doctor on other practitioners.
11 Now, the present model of the professions isn't valid
12 anymore. And what is happening to the professions has already
13 happened in industry.
14 In industry, with automation, we start breaking jobs
15 down into smaller and smaller items. And the great invention
16 of Henry Ford is that he put machine and man together in some
17 sort of working order. That was his social invention. He put
18 them together -- these small jobs, smaller and smaller jobs,
19 that men had to do with a machine.
20 And what that means is that we have to think of
21 specialization in a different way. We used to think of special-
22 ization that a physician was a specialist as against other
23 people. Now a physician is not a specialist as against other
24 people -- though he still is. He himself has specialized.

25 But a shoemaker used to do the whole shoe. Now he

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1 does the last. Someone else does the heel, and someone else
2 does something else. He doesn't do the whole shoe anymore
3 except in esoteric places in the Village and in Italy where
4 people want this kind of shoe.
5 So the meaning of specialization has changed. Special-
6 ization means now smaller and smaller jobs which require an
7 integrator, which require people to put them together.
8 So if you go on the assembly line at Mayo Clinic,
9 each of the specialists now in the professions sees you, and
10 at the end of the line some guy has to put you together again.
11 And we call him what? The internist.
12 And all the management schools in the country are
13 trying to form groups of people who will be the "internists"
14 for management. And these people are trying to become profes-
15 sional people.
16 So we need integrators.
17 Now, let's go back to that other question, and that
18 was the question of my book: What happens to professional
19 people in bureaucratic situations? What happens to profession-
20 al people in teams? Do they become what White and Mills and
21 Reisman thought of as the organization man? Do they become
22 so conforming that they really don't give us the kind of
23 service that we need?
24 If you are a patient and you are sick, very sick,
25 you want a man who can think freely, who doesn't have to

follow certain kinds of rules. Because you never would have had to go to the specialist if you could have gotten cured before that by a routine person. You want someone who can think out a problem and think of it in a different way and is free enough to be able to help you.

So we have to find out: Is it possible for a person to have independence and autonomy, two of the very important words in a profession. Independence and autonomy.

Now, educators are accustomed to that. And in the best schools we have that. So it may be possible thatcertain organizations can be set up so that for certain things, professional aspects of our lives, we can have independence and autonomy.

All right. We can't have it in room assignments. But we don't really need it in room assignments.

We can have it in terms of what shall we teach, what kind of research can we do, and the better the school, the more freedom you have.

So there are organizations set up to give us our independence.

I will forget about these notes since I am not following them anyway.

In my study what I found was that the organization, in fact the entire profession, of élites -- the élites -- did have this independence and autonomy.

They were conforming in terms of dress and where they lived. I took the entire sample of partners for three law firms. If they lived in the city, if they didn't live in the suburbs, they all lived in one section of the city, nowhere else. Not one of them. So they were conforming in terms of that.

In terms of dress they certainly were conforming. They all wore the hat, the suit, the Brooks Brothers suit, the proper tie. And I think if you did not wear that there would be a wearing out process -- I mean a weeding out process -- wearing out too, but weeding out also.

Of course, it takes ten years to become a partner. By that time people know you, and by that time you know what is expected. But it really starts much earlier than that, since a lot of these people were born into a social class that expected them to dress this way anyway, so they may not have been conforming expediently. This may have been their way of life.

Half the people in my sample went through prep school in terms of the partners. Thirty-three per cent of them were in the social register. So you can see what kind of special homogeneous group I was studying.

Well, what I found was that, while they did dress in a conforming manner and while they did live where they were supposed to live socially, they didn't conform in what we

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usually call-- Well, they didn't expediently conform. That is, they didn't conform in terms of their work for the benefits of the job.

They conformed in what I call creative conformity. And that means that the situation demanded creativity. And if they were going to become partners, they had to be creative.

It all started with training, which is part of the definition of a profession. It started before the law school but probably in the law school too, especially for law review people.

Law review people are those especially bright people who have their own journal in which they decide whether the professors' articles are going to be published. They then are really arguing on a basis of equality, which is part of what the definition of "professional" implies. That is, it is a body of equals, even though it may not be true. It is a body of equals, and the law schools are training them to be a body of equals.

What happens with the case method is when you go into a law school that in the case method the professor says, "State the case." All right. And you state the case. And then what happens is that the law professor then tries to trap you and says, "Well, what can you use this case for?"

And you say, "Well, in such and such versus such and such and such this happened."

1 And then they argue back and forth. And this is
2 something that those of us who are professors don't do enough
3 of in other classrooms. But in the law they do this. In the
4 law they force you to fight back.
5 And what these firms try to do is to force the clerk
6 to fight back. And both of them agreed, the clerks and the
7 partners agreed, that this was something that they had to do
8 if they were going to stay. They had to argue, but they had
9 to argue in a polite manner, in a conforming manner.
10 They couldn't say to the partner, "Listen, you don't
11 know anything about this. That's really not your field."
12 They had to say as one of them did say while I was in the room
13 The partner came in. After we went through the social busi-
14 ness, the partner had a brief the clerk had written, and he
15 handed it back, and said, "I don't like such and such."
16 And the clerk said, "Well, the client wanted it, and
17 it doesn't do any harm."
18 The partner said, "Okay."
19 Then he said, "Well, I sure don't like this."
20 And the clerk said, "Perhaps you haven't seen the
21 latest opinion. May I get it for you?"
22 So he was still keeping the hierarchy, but he was
23 telling him just as politely as if he had said it, "Look, you
24 don't know what you're talking about."
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25 The partner, however, who had been through the same

thing, because most partners, except defeated Presidential candidates and some Cabinet Members, start from the beginning-- Not Stevenson and not Dewey or Davis or Willkie. They all have their names on the top of these firms, but they start at the top. And Nixon. None of these people start from the bottom. They started from the top.

And then they argued. And finally they wanted to break it off, but the clerk wanted to continue.

He said, "This is very important. May I see you this afternoon?"

The partner wanted to keep this on a professional basis and said, "Yes. What is a good time for you?"

The clerk said, "Is two o'clock all right?"

And then they met and kept going.

So this is the kind of thing that occurs in these law firms.

Now, my next question in my next study, and one that is much broader, is: What happens if you are a house counsellor. That is, if you are house counsel for General Electric? There are 200 or over of them.

Now, you are working for one client. We are going a little further now than I went. They are working for one client. And they are called the "kept lawyers" of industry. In Texas they are called the "stall bed lawyers," and so on.

In other words, the implications are that they are

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not professional people.

One of the ways of looking at that is that professional people have privilege, a concept of privilege. Not all professional people have that, but lawyers have that, physicians have that, and I assume some day that you people will want it or have it or will have to fight for it in the courts.

But somewhere along what people tell you should be privileged. And I don't know what the decision is yet for you.

But one of the problems here for the house counsel is that certain people said, "No, you're not the house counsel. You're really part of the corporation, and therefore you can't keep secrets about yourself."

They said, "No, we're lawyers. And even though we are working, we are separate."

And the question is for me whether there is enough force in the culture of lawyers to keep them independent. And it is something I call professional bureaucracy. It is a structure that is outside of bureaucracy but formed by professional people. It is their rules and their norms, which is part of what is a definition of "profession."

Now, another thing that is going to be most interesting for you, because I think it fits in to your heterogeneo society or group to the extent that you are organized, is that there is no such thing as a lawyer anymore. We used to say "lawyer," and I said that all but one per cent of the popu-

lation knew something about lawyers. Well, it turns out there isn't such a thing as a lawyer, because lawyers are so different in terms of a continuum that they are like day and night.

A man named Carlin here at the University of Chicago wrote about the solo lawyer. His father happens to be in a large firm in Chicago, but he wrote about the solo lawyer.

They do absolutely different things than my lawyers. First of all, they come from different backgrounds. They were sons of immigrants, most of them. Secondly, they went to night schools, which are now disappearing. Third, they practice what is left over in the law, the criminal law, negligence cases, the bill-collecting, the divorce law, the kind of law that the people I studied wouldn't touch, would not touch.

They practice in different courts. They practice in the lower courts. They don't practice in the higher courts.

They go to the schools where they are not taught the same kind of independence, though a lot of them get it in a different way because they are scrambling for it. They have to stay around the courts picking up clients, whereas the people that I studied don't pick up clients. The young fellow comes in, and the clients are there. The clients have been there for 50 years. The clients can't leave. They hardly ever leave. The only way they leave is if there has been a merger and they have to decide between two law firms. They just don't leave.

ERIC

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1 If you recall Auchincloss and his books about lawyers,
2 he has one I think called "The Law of the Lions," where the
3 client wanted to leave but the interrelationship was too great.
4 Because one of the things the large law firm does is give you,
5 the client, their lawyers, their graduates, you see. Only one
6 out of 12 becomes a partner, and the others start going into
7 the corporations. And so the relationship gets thick.
8 And what is the corporation anyway? The head of the
9 corporation isn't the corporation. He is just one aspect of
10 it.
11 So they have the neighborhood client. They have to
12 bribe the police and the petty bureaucrats. They do the ambu-
13 lance chasing. They sit around the courthouse and the bail
14 shops and compete for clients.
15 With the other lawyers, 70 per cent of them came
16 from Yale, Harvard, or Columbia Law Schools. They were at
17 the top of their Ivy League colleges. They can get a job any-
18 where, especially if they were law review and had a personality.
19 They were mostly Anglo-Saxon, though this is changing somewhat.
20 In one firm, 75 out of 100 associates were on the
21 law review. I have never seen a brighter group of people in
22 one organization in my life -- never. More Phi Beta Kappas
23 than I am sure on most faculties were in these shops.
24 Now, it is true they get dull in a way, because they
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25 are getting so specialized. But the people who use them want

them to be just the way they are, and they know how to work together. So what I am saying is, a lawyer doesn't mean a lawyer, and a physician doesn't mean a physician. The psychiatrist, the general practitioner, and the specialist all perceive things differently. All see things differently. And this may be an item of importance to you, because in this group -- not in this particular group, which is much more homogeneous than I think your wider association is -- it is so heterogeneous that you have to think of what you have in common.

Lawyers have something in common. They have a common education, which is not quite as common as they think, but it does have the basics which they have in common, and then they start spreading out.

So what we found for lawyers may be true for every occupation.

And as to the word "specialization," going back again from that of the specialization in industry, the specialization in medicine, specialization in your field becomes greater and greater.

Now, I sense that some of you don't like what is happening and are really fighting this. I also feel what is going to happen is that eventually there will be so much information that, whether you like it or not, you are going to have this problem of smaller and smaller specialization -- unless the machine comes in to help you as it came in to help industry.

1 In other words, what happened to the specialization
2 in industry? The new automation is putting all those jobs that
3 man had to do, the small jobs, together so that a lot of the
4 jobs are becoming lost.
5 A student of mine had a project this year. I don't
6 know the exact figures, but I will give you an impression. A
7 student of mine went through the Dictionary of Occupational
8 Titles to see how many jobs disappeared. Because we know how
9 many jobs were added. But he wanted to see how many jobs and
10 what jobs disappeared.
11 Well, it was over 4,000 jobs that disappeared in the
12 ten-year or 20-year period that he took. And most of them had
13 to do with where the machines came in.
14 Now, if the machines come in for medicine, a lot of
15 the work that physicians have to do in even diagnosis will be
16 done by machines. And in law the basic "shepherdizing" of the
17 case, which means what are the precedents, will eventually be
18 done by machine. So we won't need the clerk in the same
19 capacity, and this may change things again.
20 And it may give you more time to do other things and
21 be broader. So the machine may be the hope of being broader.
22 Now, what machines are going to come to help you I
23 don't know. But in the meantime it seems to me, from my own
24 experience in sociology, that what is happening is that we are

25 becoming narrower and narrower, and many of us resent it, and

I think many of you will resent it, especially if you think in terms of -- what did you call it last night? -- multiple --

DR. MYKLEBUST: Handicap.

DR. SMIGEL: -- multiple handicap.

To deal with these kind of people, you have to know a lot more than other people.

And in geriatrics they are doing the same thing. They don't think in terms of one sickness. They think in terms of many sicknesses. There is getting to be a field of geriatric physicians.

Let me go on. What this means, this joining together, is that we don't know who the client is. Is the boss the client? Is the head lawyer the client? Who do we work for? And a professional has to work for the client as if he were the only person. But maybe if you want to get ahead you have to please the boss, who is not the client. And this is another p roblem that is involved here.

All right. Now, there are other difficulties in defining a profession. One of the difficulties is that the difference between occupations and professions is getting smaller.

There is a man named McKeever, who I say is the last of the "know-it-all" sociologists, because he is a political scientist, he is a philosopher, and he is a sociologist. And he doesn't worry about the new terms.

He is also I think 80 years old.

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1 But he is one of the last of the all-around sociolo-
2 gists. And what he found was that the pure economic associa-
3 tions, which used to worry just about pure profits, are now
4 not just only worried about pure profits but they are worried
5 about society. So that Macy's, when it has its Thanksgiving
6 Parade, has a parade that it no longer needs for the advertis-
7 ing purposes but has it as a public service as well as whatev
8 advertising benefits there are. But Macy's doesn't really
9 need that expensive parade anymore.
10 The physicians, on the other end of this, have an
11 association working for them in terms of the pure economic.
12 While they keep up their other functions, they are working in
13 such a way that the professions are going closer to the occu-
14 pations and the occupations are coming closer to the profes-
15 sions.
16 There is a man named Nelson Foote who now predicts
17 the future for General Electric so they can know what kind
18 of electricity, let's say, ladies will want in the year 2,000
19 In other words, he is trying to predict the future sociologi-
20 cally. He wrote an article, when he was doing something else
21 about professionalization in Detroit and said eventually ever
22 body will be professional because we get out so many of these
23 jobs.
24 Some other people -- like Wolensky, who wrote an
25 article "Professionalization of Everyone?" -- find that isn't

A man named Gude working with librarians found that wasn't the case either.

This brings us to some of the definitions.

In a book called "The Academic Man," a man named Wilson gives this definition and gives the following criteria:

You have to have prolonged and specialized training -- that is the first of this -- based upon a systematic intellectual tradition. You just can't pick it up overnight.

Prolonged and specialized training based upon a systematic intellectual tradition and not acquired through mere apprenticeship.

So, according to this definition, lawyers were not always professional people. They became so later.

And this prolonged and specialized training is usually attached to some academic institution. That is why the chiropractors and the eye doctors try to get involved with academic institutions. And that is why the chiropractors keep adding years to their educational requirement in an effort to gain recognition.

The next one is that we have rigorous standards of licensure. There has to be some licensing procedure, some recognition that this is important by the State, and the fulfillment of which often confers upon the functionary a degree or title signifying specialized competence.

So that the public knows that the Government has said

"You're okay for whatever monopoly you have over the body, which is your area, what you can do what with."

Of course, each of the professions fights over these areas, so in psychiatry there is a big fight, or has been a big fight, between the clinical psychologists, the psychiatrists, the psychiatric nurses, the psychiatric social workers, and so on, all fighting over the same area.

So the physician is licensed, the CPA is licensed, the lawyer is licensed, and now more and more people are getting certificates, and pretty soon the certificate will become a cheap kind of licensing. We won't recognize it. Because too many people are getting certificates in too many things, and it gives it an inflationary look.

The license really gives you access to some part of the body, and you say, "This is mine, and that part of the work is your monopoly."

Another thing that we have is the difficulty of testing the intricacy of work. If the work is simple, then others can tell what you have done wrong. If the work is not simple, then the public doesn't know. In fact, it's hard for your colleagues to judge you unless you have worked as long as people have in the law firms together before they become partners. But mostly you can't tell.

How do you know if a physician has done the wrong thing except in some cases? Even when they say there is a

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malignancy and there isn't, that doesn't mean he was wrong. Maybe they have to find it out. Maybe this was the only way, and only his guess was wrong. Maybe he still did the right thing. It is very hard to find out.

Now, there are simple things. If he doesn't wash his hands before the operation, he is wrong.

And there is one case where a guy sued a physician in the Navy because at the second operation he had for the same thing they opened him and found the towel with "U.S. Navy" on it. And this is an actual case, and it is in the lawbooks.

Well, obviously he was wrong.

But really you can't tell. Certain things you can't tell. And when you can't tell, this means it is harder for that occupation to become a profession.

Another criterion is the absence of precise contractual terms of work. Now, this is changing, because people do have contracts now. But still professional people are fighting not to have the contracts as defined as they are for workers.

You know what is happening in every big factory. There are hundreds of professional people. Now, RCA has engineers and chemists and so on. There are two or three books on this subject about the contract work and how the professional fits in.

There is a war going on right now between the professionals and the contractors.

1 The absence of precise contractual terms of work.

2 Then limitation on self-interest, which is one of the
3 major points. The practitioner is there not to make money,
4 though he has to make some, and what that is differs under dif-
5 ferent circumstances. His major point of view is supposed to
6 be service to the community, service to the client, service
7 to whatever he is being professional about.

8 And every occupation has a professional association.
9 Every profession has a professional association. Some of them
10 that are not professional try to have professional associations
11 because they try to meet the criteria of professionals. But
12 all of them have it.

13 Most of the definitions that I had-- And I collected
14 20 or 30 of them and have just given you, and I am giving you
15 the parts that usually overlap in all of them. Most of the
16 definitions have something about professional associations,
17 because professional associations have to be in a sense the
18 policeman for the association. Because if you have people
19 breaking canons of ethics, then that reflects on everybody.

20 So at least the élite of every profession want
21 codes of ethics and want an association to police them.

22 In New York City, the City of New York had 1,140
23 cases, and 44 finally came up to the Court of Appeal, which
24 is the way it is finally settled.

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25 DR. KIRK: What is the difference between the AMA

1 and the Teamsters Union? Is one an association and the other
2 a union?
3 DR. SMIGEL: This is the part I left out in McKeever's
4 scheme. I left it out.
5 DR. KIRK: Are both of them unions by a different
6 name?
7 DR. SMIGEL: No, until recently unions were only
8 interested in self. They were bread-and-butter. More recent-
9 ly-- And one of the reasons Reuther tries to pull out of the
10 AFL-CIO is because he wants to do more in terms of societal
11 interests.
12 But the professional organization have a journal,
13 they have meetings, they talk about canons of ethics which are
14 supposed to protect the public. And so that you are going
15 to come to finally is that most of this is on a continuum.
16 This brings us to the point. In other words, only
17 in the core of the professions can you say this is a profession
18 and this is an occupation. But it is on a continuum.
19 Actually, there are some studies to show that you may
20 have a number of continuua, and you probably have to add it up
21 in some sort of a fashion and then make arbitrary decisions
22 about what you are going to call a profession. But it is on
23 a continuum.
24 What is happening now is that a lot of people are
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25 studying not professions but professionalization. What is the

process an occupation has to go through to become a profession?

Gude said to the librarians, "You will never become a profession" -- because he thinks their work is so simple, in that we know it, and even though we don't know where the book is hidden that's a simple matter too.

He says that if we come to them for it, then we haven't really done the work in our field. Now, maybe for a child they may have something. But he didn't feel that.

At any rate, he didn't say they weren't becoming professionalized. He says that by licensing, which they don't have yet but which they want, by the degrees they have to take and I think they already have a Ph.D. and some of them are going on to that -- they are becoming more and more professionalized. But now they have an association, and now they have requirements, and now they are trying to force universities and other places just to hire professional librarians. As soon as they have enough professional librarians -- as soon as they have enough they will be all right.

DR. KIRK: What do you mean by "all right"?

DR. SMIGEL: All right from their point of view. That is, they will be closer to professionalization. I don't know that they need this. And Gude says they really don't. But from their point of view they do.

How much time should I take? Five more minutes?

DR. MYKLEBUST: Yes, five more minutes.

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1 DR. SMIGEL: Here is one that someone did for socia
2 workers that I will give you very briefly.
3 Systematic theory. That is part of the education,
4 almost the same as before.
5 Authority. And that is the place where the custome
6 is not always right. He has to listen to the profession.
7 Community sanction. An occupation wanting to becom
8 a profession wants community approval. They have to be recog
9 nized. Otherwise it doesn't matter almost, except to you.
10 In other words, you are saying you are a profession, and they
11 are not saying it. If they are not, you don't get the recog-
12 nition.
13 Control over its training centers, over admissions,
14 which can be good or bad.
15 Confidentiality.
16 And a monopoly over a certain area.
17 Regulative code of ethics.
18 And something he hasn't talked about but which I
19 think is very important -- the professional culture, values,
20 norms, and symbols, which take a long time to develop. But
21 each profession has it.
22 Now, the two that I studied, the two that I know
23 most about, have it for the élite at least. In lawyers it
24 was this whole business of the need to be politely argumenta-
25 tive and to work your point until you are convinced that you

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1 are wrong.

2 In academia, it is academic freedom and the norms t

3 go with that.

4 In a book that Lazerfeld wrote about the academic

5 mind, which he wrote after McCarthy was in power, and where

6 he wanted to see what McCarthy had done to freedom of thought

7 which is part of our job in any profession, he found that the

8 more élite the school, the more McCarthy attack it and the

9 more it attack McCarthy.

10 I think it is true about every profession, if we

11 knew more about them, that every profession has certain rules

12 and regulations that can keep it free. And for those that

13 are confident, it does keep them free. But you have to be

14 confident. And you have to be an élite. And the élite have

15 to try to instill this in others, and this is a tremendous

16 job.

17 Because if you look at Carlin's book on the solo

18 lawyers, these lawyers are struggling to exist. These lawye

19 are struggling to eat. They are not going to worry so much

20 about the refinements in a culture.

21 Well, there is more, but let me try to sum it up

22 simply by trying to say again how difficult it is, first,

23 to define a profession, but that there are enough clues for

24 us to get a picture.

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25 Second, I believe a profession is on a continuum.

1 Third, the more heterogeneous you are, the harder it
2 is, especially if you are starting in to form one, but that
3 this may not be the final limit, since medicine and law, the
4 models of the professions, are now getting more heterogeneous
5 than they once were.

6 So that's my talk for today.

7 DR. MYKLEBUST: Dr. Smigel, thank you very much for
8 this most enlightening discussion.

9 I think that some of us here would feel that in the
10 first place it's very broad in its concept and helpful, a
11 little disturbing perhaps in the way that Dr. Smigel is able
12 to look at a profession and say where you fit, where you fall,
13 what you are, what the problems are, and so on.

14 This is very helpful to us, and we appreciate it
15 very much. We will probably have time for some discussion
16 later.

17 I now feel that we need a cup of coffee. Could we
18 take a little coffee break now, please, before Dr. Kirk?

19 (Whereupon, a recess was taken.)

20 DR. MYKLEBUST: Well, we'll go right on now. Sorry
21 we have to try to keep on schedule, but you know this is es-
22 sential for all of us.

23 I now have the pleasure of getting Dr. Sam Kirk be-
24 fore us with his presentation. As you know, he is going to
25 discuss the problem of the need for clarification.

1 Sam.

2 DR. KIRK: I appreciate Mike's title -- the need

3 for clarification -- rather than just clarification. If I had

4 to clarify, he would have given me an impossible job. (Laughter

5 I do have some introductory comments about how you

6 take on a problem and rather thoroughly cover the subject.

7 But I want to say first off the record --

8 (Remarks off the record.)

9 I thought I had better start out by indicating to

10 you my confusion. I think Mike asked me to discuss something

11 about the problems of clarification because he heard a speech

12 I gave in New York entitled, "Are We Confused?"

13 I think this is a very confusing field, although at

14 one time it was not a confusing field.

15 I remember many years ago when I was maybe 22 or 23

16 I got a job teaching in a school near Chicago for delinquent

17 retarded boys, and I got that job. They called me resident

18 teacher.

19 Fortunately, in those days there were no certifica-

20 tions for teachers, so I could get the job and explore all

21 kinds of things.

22 At this particular place, which was in Oak Forest,

23 Illinois, I read a case record of a boy who was 12 years old,

24 couldn't read, became delinquent, IQ around 80. And someone

25 had stated that this boy should be diagnosed or was diagnosed

1 as a case of very severe alexia.

2 I didn't know what alexia meant, so the next day I

3 went to the library of the University of Chicago and picked

4 some literature and began reading, and one was Marian Monroe

5 work at the Institute for Juvenile Research. I studied that

6 My particular job was to work in the afternoon, pu

7 the boys to bed with the nurses, and do a little recreation,

8 try to teach them. It was sort of a heterogeneous job --

9 and also bus-boy -- since I had classes at the University of

10 Chicago in the morning. So I called this boy after the kids

11 went to bed at eight or nine, and I began experimenting with

12 teaching him how to read. And I found out he could learn.

13 And within about six or eight months I had him reading up to

14 about third grade.

15 I was so proud of this I wrote a letter to the

16 Institute for Juvenile Research saying I really cured this k

17 And they asked for him to go in there. And he wen

18 in to the Institute for Juvenile Research, was examined by

19 Marian Monroe, whereupon I received a letter asking me to re

20 port the techniques I used for teaching this child and how

21 I found out how to teach him.

22 I went down there and said I had read some of the

23 materials and applied some sort of a phonic system to him an

24 found out he could learn, and also that I wanted to learn

25 something about diagnosing reading disabilities, and I would

write the report providing they showed me how to test kids.

Well, within about four months they paroled this bo and put him in the public schools, back at home, because he was a juvenile court case.

At that time I thought, you know, that this was rather simple -- kids that can't learn.

I picked up a few more children and thought I coul teach them to read. And the problem was relatively simple.

I got a job in Michigan to do research on reading with mentally retarded and other problems. And when I got there they began referring all kinds of children, aphasic children, children with perceptual handicaps, as they are called now, but I didn't quite know what they were, behavior problems, fingernail-biters. You know. It wasn't just plai diagnosing reading.

So my job was to do research half a day and to do some kind of treatment or remediation the other half-day. And we had some students from the University of Michigan.

That's how I got started in diagnosing remediatio

Well, naturally, at that time I hadn't had any wor in this field, and the language problem was quite important in some of these children. So I went in to Wayne University took a course in speech correction in order to find out wha to do. I can tell you that that course didn't help me very much.

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1 Then I went into the University of Michigan and took
2 two seminars with a Dr. Muyskins, who was head of the speech
3 pathology department. He had a big beard and ran for Mayor, a
4 he was a real character.
5 Do you know him, Mike?
6 DR. MYKLEBUST: No.
7 DR. KIRK: He was a real character. He was theoreti
8 cal, was physiological, very physiologically inclined, and ex-
9 plained many things in terms of physiology.
10 And then later, after I got my Ph.D., I took some
11 work in the deaf, because they were working in the language
12 area. Two courses.
13 I had a workshop for the visually handicapped that
14 I took one summer.
15 The only area, Mike, that I have never taken a cours
16 in is in the field of mentally retarded. So don't ask me any
17 questions in that field, because I have never had a course in
18 that.
19 A lot of people have been saying to me, "Why don't
20 you send your credentials in to the State Department of Public
21 Instruction and see if they will certify you as a teacher of
22 mentally retarded, since everybody uses your book for training
23 teachers?"
24 I say I don't want to embarrass them. I'm sure they

25 will turn me down flatly. I haven't had the practice teaching

or the sequence of courses we use to train teachers.

That's just a little bit by way of introduction to indicate that at one time I had quite a few answers to these, and it was rather simple. You'd take children with problems and try to do something for them, reading and visual perception and language and that sort of thing.

One of the areas I was particularly interested in was the theories in physiology, so after a few courses in physiology and physiological psychology I ran an experiment on rats -- mostly because they wouldn't let me cut up brains of kids that were left-handed, mixed dominance, and that sort of thing. And I had a lot of fun teaching rats to read. You know, they can jump at a yes versus a no. And you test their handedness, cut up their anterior lobes, shift their handedness, and see what happens to their visual perception.

I really got no place on that. I mean after about two years of research in a physiological laboratory I couldn't get very many cues to this transference to the kids themselves.

The next thing that faced me is when I ran a pre-school for mentally retarded children. Mental retardation is kind of a simple deal, you know. You can define it by IQ. And if you accept the hypothesis that a low IQ shows poor integrity of the nervous system, then these children have poor integrity of the nervous system by inference from a low IQ.

1 But when you start setting up a school for young kids
2 that test below 75 IQ on two or three psychological tests and
3 you begin to work with them rather intensively, you find that
4 your diagnosis of mental retardation is a little bit simple.
5 Just to give you one example, because I think it falls
6 more under the caption of learning disabilities than anything
7 else, here is a girl referred by a pediatrician saying, "I
8 think this girl, whose IQ is below 50, from the psychological
9 clinic, is a little bit too low for your pre-school, but you
10 might take a look at her. I recommended institutionalization,
11 but the parents refused. You might take her since you are
12 looking for kids at that age."
13 This girl has many physical problems. First, we
14 have had an operation at the age of three for cataracts,
15 to remove cataracts. She has a marked case of nystagmus.
16 She is diagnosed as legally blind by the ophthalmologists.
17 And she has a low IQ.
18 The etiology was rather clear. It was a case of
19 rubella.
20 So we brought this little girl in, and her verbal
21 ability looked to me like something a little higher than IQ [illegible].
22 She couldn't see too well because her eyes jumped all the
23 time.
24 We would ask her to do something, and she would
25 stumble over things. Sometimes she could see, and sometimes

1 she couldn't.

2 We asked the question: How do we train this kid?
3 What do we work on?

4 Well, let's work on her area of greatest deficit.
5 Apparently it is in the visual perceptual field. If you give
6 her a long enough time, with her eyes jumping all the time,
7 she could recognize something.

8 So I said, now, her verbal ability for her age and
9 IQ is not too bad. She seemed to be rather a sociable girl,
10 rather affectionate, and maybe we ought to see what we can do
11 for her. What do we do about her vision?

12 So I concocted a little experiment in which we would
13 take her up to a room and show her a picture of a cat and say,
14 "Do you know what it is?"

15 If she didn't know, we'd say cat -- or dog -- and
16 we'd come back to cat and then dog, and eventually we used
17 a tatistoscope, gave her a minute to look at it, then half a
18 minute.

19 We fooled around with this girl for around six months
20 At the end of that time we put all those pictures on the
21 tatistoscope, and she recognized them in 125th of a second.

22 Boy! Legally blind? You snap these things like
23 this. What a diagnosis!

24 I was so proud of our training her vision, you know,
25 that I told the mother to take her back to the ophthalmologist

1 who diagnosed her as legally blind.

2 She did. The ophthalmologist looked her over and

3 said, "She's legally blind. She ought to go to a school for

4 the blind."

5 The mother came back and says, "Legally blind."

6 So I called this doctor up. I said, "When you quit

7 work around five," I said, "will you see me around five minut

8 after five? I have a professional thing to discuss with you.

9 I want you to examine my eyes."

10 I got this girl and took her to the office, and I

11 said, "Doctor, I want you to see what this girl can do."

12 I had a book in my hand with pictures. I said,

13 "Sharon, tell the doctor what you see."

14 She told him everything in the book, all the pictu

15 the stories about the pictures. I did another one and anoth

16 one and another one.

17 I said, "How can you say this girl is blind or

18 even mention the word blindness when she can perceive that

19 well?"

20 He says, "Her eyes are the same."

21 Maybe we are training a central process, because w

22 really train speed of perception, recognition and speed of

23 perception.

24 Now, this girl went on at the age of six and a hal

25 into the regular school. They didn't have any partially see

classes there.

At the age of ten, when we reexamined her, her IQ was 85 in the Binet and about 87 on another test. She was reading about middle second or third grade without special training or things of that sort.

Maybe she would have done that anyway -- I don't know -- without this training.

But I mention this case because here you are dealing with, let's say, mental retardation and find you have something else.

We had a little girl that came in, had been given an audiometric test. She's deaf. But somebody else tested her and says she doesn't have a hearing loss. And the EEG on her didn't find anything.

This girl had been diagnosed in a number of clinics. Some said she's deaf. Some said she's slightly hard of hearing. Others said she can hear.

But she couldn't talk at age five, couldn't say anything. And is that due to deafness?

Well, we fooled around with her, trained her as you do a deaf child with receptive aphasia, expressive aphasia. And within about a year or so we made considerable progress with this girl in the auditory field.

So I think this is probably one of the problems that we have in clarification: What is this category we are calling

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1 learning disabilities, or psychological disorders, or whatever
2 you want to call it? What are you going to call this girl that
3 needed remediation in speed of perception to counteract her
4 nystagmus? Her eyes jumped 15 times to see something or recog-
5 nize something. Can we train her to see these and recognize
6 these objects with only one jump of the eye in between whatever
7 happens in the central process?
8 Because I'm sure we didn't do anything with her
9 peripheral vision. We didn't change her nystagma. She still
10 had a nystagmus. She still had some pure visual acuity. I
11 don't think we did a thing with that, but I think we did have
12 her use the brain, so to speak, the central process, that could
13 compensate for this peripheral handicap.
14 Now, we have, as everybody knows, bandwagon effects
15 on everything. Many years ago people preferred to call it
16 brain-injured instead of idiots or imbeciles. I mean it's
17 kinder to the parents to say your kid if brain-injured than
18 to say he's an idiot or an imbecile.
19 They kept saying, "My child is brain-injured." And
20 this is a kinder term for them. If he is brain-injured, they
21 have an explanation for mental deficiency, and it isn't as
22 harsh as the terms "mental deficiency," "idiot," and "imbecile."
23 So we changed the words to "mental retardation" and
24 things of that sort.
25 So we have all kinds of disabilities coming into

1 this particular rubric, whatever it may mean.

2 At the CEC convention in Toronto I got a telegram

3 from Senator Morse asking if I could come in to Congress and

4 explain to the Senators what we meant by learning disabilities,

5 that there was considerable confusion. You were there, weren't

6 you, Selznick?

7 DR. SELZNICK: Not that particular one.

8 DR. KIRK: They wanted some clarification, because

9 the pressure from the outside was so great they had to have

10 some clarification.

11 So I said, "Well, this is a broad field, and I don't

12 know that I can. I will bring anybody you want."

13 He said, "Bring anybody you want with you."

14 So I called Richard Paine, who was a neurologist in

15 Washington and who does a lot of work with children, a well-

16 recognized person, and asked him if he could testify about

17 what he thought from a neurological point of view.

18 I took Jean McCarthy from the public schools who

19 is running a program -- we have a practical public school

20 program -- the neurologist and myself.

21 We went down there and gave them little speeches.

22 They asked questions: "What is the difference between mental

23 retardation and learning disabilities? How do you pinpoint

24 this field? How do you differentiate it from the disad-

25 vantaged and things of that sort?"

1 Well, in my testimony -- I read it later, and I still
2 believe what I said -- I made the statement that these children
3 have discrepancies in psychological functions, that some grow
4 and some don't, and that we have to determine the learning
5 disabilities by determining whether a child has psychological
6 deficits inhibiting his ability to learn.

7 And I also said that some of these children, of
8 course, have correlated physiological problems.

9 I didn't use the term "brain injured," but I used
10 "physiological."

11 Now, when Wayne Morse wrote the Elementary and
12 Secondary Education Act, they put the pressure on, and he
13 included -- with deaf and blind, crippled, and so forth --
14 learning disabilities. There is a caption called "Health
15 and Other Services."

16 So when he wrote it up he said, "Professor Samuel
17 A. Kirk from the University of Illinois has produced research
18 evidence for us in which he said that this condition is
19 physiologically based or has physiological deficits."

20 He changed the term "psychological" to "physiological."

21 Now, that created a real confusion for the Office
22 of Education, because if it is physiological then it is out
23 of the hands of educators and has got to be in the hands of
24 the MD. Therefore, if we are going to deal with these kind,
25 it ought to be under the medical auspices because it is

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written in there "physiological."

I said, "Did I say that?" I could, you know, under the pressure of testimony. And I read it carefully, and I did say-- The only time I used "physiological" is that, of course, some of these children have-- That is, there are many reasons for this, and some of them have physiological correlates.

And Richard Paine told them the same thing. I read his testimony. He told them it is an educational problem although there may be some children-- They can find a lot of other children where they can't find any neurological deficits. And he practically told them what I told them. It is an educational problem in children.

But, anyway, this needs clarification not only between us -- and we will have trouble clarifying, as you will notice -- but before the general public, and we also have Congress, the Office of Education, the Neurological Institute.

Unless this is clarified, we are going to go off into millions of directions.

You become flabbergasted, you know. Mike and I attended the first meeting of ACLD in Chicago, before it was that, and the meeting was to call together all these associations called "Funds For the Perceptually Handicapped," Society of Brain-Injured Children, Society for Learning Problems. I guess there were about a dozen different names for parent groups.

So they met in Chicago, and Mike and I both presented

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1 papers to them. I don't think we differed very much in our
2 point of view, if any, at the time.
3 It ran something like this: "Now, we know that there
4 are possibly correlated biological factors. If I were a re-
5 search man and was interested in the biological correlates
6 of some of these psychological and educational deficits, I
7 would tend to use some sort of brain terminology, because that's
8 what I want to do when I connect the brain with behavior, or
9 the brain interface, or whatever you want to call it."
10 I said, "If you are interested in doing something for
11 these kids in a learning-teaching milieu situation, then it
12 might be better for you to use some sort of a behavioral term
13 like 'learning disabilities' or 'psycho-educational work' or
14 something of that sort, because you are not really going to do
15 anything with the brain particularly -- unless if some of
16 them are given drugs you might."
17 Well, they got together the next day, or so forth,
18 and came out with the Association for Learning Disabilities.
19 Then they got ambitious enough to run a meeting, and
20 they ran a meeting in Tulsa and got a lot of speakers, pretty
21 good speakers I think, from all over the country, England,
22 and other places.
23 The big complaint about that meeting was that the
24 hotel in Tulsa could not hold the crowd that came to listen
25 to this Association of Learning Disabilities. It was jammed.

1 They couldn't get luncheon tickets. They had plenty of luncheon
2 tickets, but not enough.
3 The New York people said to them: "This is a hell of
4 a place to go, out on the farm here, and have a meeting of this
5 magnitude. Why don't you come, you know, to a respectable city
6 instead of out here in the oil wells of Tulsa?"
7 What is Tulsa? 200,000?
8 DR. MYKLEBUST: About.
9 DR. KIRK: They didn't say it exactly in those terms,
10 but there was considerable complaint.
11 They said, "Okay, New York. You run it."
12 So last year, in March, they held an ACLD meeting --
13 some of you were there -- in New York. And they took over
14 the Waldorf-Astoria Hotel, which is a tremendous hotel.
15 DR. BLAIR: It wasn't big enough either.
16 DR. KIRK: Then the fire marshals stopped the ele-
17 vators going to the convention floors because they couldn't
18 hold that many people. They had 6,000 people registered that
19 came from all over to learn something about learning dis-
20 abilities.
21 This is a parents' organization, practically, with
22 the help of some professionals.
23 And now they are going to have it in Boston next year,
24 and I'm not sure the Boston people want it. They are resisting
25 it because they don't think they can hold the ten thousand the

might descend upon them.

And there was as much complaint. They had more complaints in New York than they did in Tulsa. Here's the "big city" in the United States.

After a day or so they took over another hotel and moved some of the meetings there. But, you know, the convention was over before they got organized.

But I just mention that as a public pressure phenomen

Gallagher tells me in Washington that 75 per cent of the letters coming in on special education to the Commissioner of Education are in this area. Pressure is very hard. Many people say the Federal Government isn't doing anything -- in spite of the fact that the U.S. Office is giving grants. Mike is chairman of the board, and they hand out a million or so dollars a year for training people in learning disabilities. They say nobody is doing anything.

We have a million dollars for research. That isn't very much, a million dollars. Probably it ought to be five or eight million. But, anyway, there is a start there.

And I think particularly in Washington, unless we are able to delineate the field in some way to make sense for Federal agencies to subsidize, we are probably going to be a little bit in trouble.

Because, like education in general, who is an educator? Everybody is an educator. You know, every lawyer

has gone through school, and he knows all about education. Every plumber has gone through school, and he knows everything about education. So everybody knows about these fields.

And what is it? And I'm not sure. And one of the reasons I told Mike I was really happy that he is taking a little initiative to get some people together is I think we ought to have this and a number of other meetings and battle ahead until we come out with something to keep it rather clear to the public.

I think one of the major difficulties that we have is that every child under the caption of "handicapped" has a learning problem. A deaf child doesn't learn to read very well. Is he a learning disability? Is this what we are talking about?

Now, many of those who came to New York had some handicapped children, the cerebral palsied, the deaf, the blind, the crippled, the mentally retarded. Are these really what we talk about when we talk about learning disabilities? Is that the category? Do we diagnose them by exclusion?

We say, "Well, no, when we look at this kid and we find he's deaf, we have a program for the deaf. We have a curriculum for the deaf." I mean there are people doing that work right now, and, therefore, we won't call him X term, whether it's learning disability or something else, because we do have a program for this kid.

1 The reason this problem arises is because so many
2 kids come in to the hopper, and the ear people say he's not
3 deaf, the people in the blind say he's not blind, the mental
4 retardation say he's not mentally retarded, but the kid isn't
5 learning or can't talk or something of that sort.
6 What will we do with him? He is handicapped. He
7 isn't communicating. He isn't doing a great number of things.
8 Something ought to be done for him.
9 "I know something ought to be done, but, I'm sorry,
10 I just take care of the deaf," or "I just take care of the
11 mentally retarded." You know, we have these categorical
12 classes in the schools.
13 Then we have this mass of kids that don't fit into
14 any of these. The multiply-handicapped that you are
15 going to talk about is one group.
16 And so we have to do something to kind of delineate
17 the program.
18 Gallagher and I were talking about this, and this
19 is partly his idea of what he is going to recommend, you
20 know, after about an hour's discussion, and it runs something
21 like this.
22 We have a group of kids that are educationally
23 retarded in the schools. We have many of these disadvantaged
24 kids. We have many kids that haven't had an opportunity to
25 go to school, kids that go to school and something happens in

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1 the instructional process and they don't learn. Are these
2 learning disabilities?
3 Is every kid that is retarded let's say in reading
4 a learning disability? And how much retardation?
5 And every kid that doesn't learn reading, writing,
6 and arithmetic in school because he hasn't been there? I have
7 seen kids 15 years old that come from Arkansas with ten other
8 kids in Champaign, and you find out they have never been
9 in to school. And they are ten years old. Are you going to
10 put them into kindergarten? Are they learning disabilities?
11 Then we have another group of kids that we identify
12 sometimes as neurological handicapped. We have the cerebral
13 palsied group. You have many kids where you can get a defini-
14 tive diagnosis of neurological handicap, developmental or
15 otherwise. Are these neurological kids learning disabilities?
16 Are all neurologically handicapped kids learning disabilities?
17 I don't think the answer is yes. It's probably no.
18 I had one cerebral-palsied girl who got her master's
19 from Northwestern and her Ph.D. from us. She was a spastic.
20 She had a speech problem. But I wouldn't call her a learning
21 disability. She learned everything up to Ph.D., even though
22 the standards are low at the university. She at least got
23 through.
24 So is every kid that has a neurological handicap
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25 a learning disability? The answer is no.

1 Is every kid that is retarded educationally a learn-
2 ing disability? Probably no.
3 Now, it is probably this area here -- (indicating
4 at blackboard) -- if we can define the overlap of a child who
5 has had we would say proper educational environment, has
6 potentially normal intelligence, who under these circumstances
7 has not been able to learn whatever we want him to learn in
8 language, reading, speech, whatever we want to classify under
9 the caption of learning disabilities.
10 Does this kid have a neurological handicap? Well,
11 maybe in some cases, yes. In some cases we don't know. In some
12 other cases, probably not. Maybe it is genetic. Maybe it's
13 something else. You see, we don't know.
14 Now, the thing to do is: How do we define this
15 overlap group, you see, between this and this (indicating),
16 because one group calls it brain-injured kids, another group
17 wants to call it something else, you see, and there it may
18 not be brain-injured. It may be genetic. It may be something
19 else.
20 Now, we could say -- and this is the point of view
21 that I have held -- that we have to operate primarily on a
22 behavior level. If this child has abilities and disabilities
23 and we can define the disabilities that are remediable, like
24 this girl-- I didn't have tests to say she is high here and
25 high here, just a clinical impression, like a lot of clinical

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1 psychologists do, you see, which is a very valid approach.
2 You don't have to have a score to know this.

3 But we knew that she just couldn't recognize objects
4 and things with her eyes and that there was a biological base
5 for it, you know, with the cataracts, and that the biological
6 base I couldn't do anything about. And she had been to
7 pediatricians and ophthalmologists, and they didn't do any-
8 thing about it.

9 But we introduced stimulation of the environment on
10 a behavioral basis in order to train her deficit, and we got
11 some place with her.

12 Now, if we can define this area in some way concretel
13 enough that it would be acceptable by legislators, by others,
14 and by schools, the way we have let's say deafness-- And we
15 read that literature in the deaf, and they don't agree, you
16 know. They haven't got it, as a matter of fact, that this is
17 deaf and this is hard of hearing. There are grades and every-
18 thing.

19 What is mental retardation? Well, we had this
20 instrument called an intelligence test, you know, and the State
21 laws many years ago said 69 and below. So you slapped them
22 with a Binet, and if you got 69 and below the legislature
23 says, "We have got a figure here. Children who are 69 and belo
24 we put in classes for the mentally retarded."

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25 What ruined that 69 is that a lot of screwballs went
out and developed some other kinds of tests, and they get 69

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1 on one test and get 84 on another, and then they don't quite
2 know. What will we do? Hide this in order to get them in?
3 Or shall we throw this out in order to not get them in?
4 I mean this was a game, you see, with these figures.
5 But we got away with it, you see. We have classes
6 for the mentally retarded. We have classes for the deaf.
7 We have classes for the legally blind, classes for the partiall
8 seeing -- 20/200 if I remember.
9 DR. SELZNICK: That's right.
10 DR. KIRK: 20/200. Or 70/200. Is that correct?
11 MISS TAYLOR: 20/200 is the one you choose to use.
12 That's the definition of legal blindness.
13 DR. KIRK: This is what we put. We tell the legis-
14 lators. 20/200. This girl was 20/200 that I was talking
15 about. Legally blind. What does it mean? It's about as bad
16 as the 69 IQ. But they accept it, you see. Maybe they are
17 getting to sophisticated.
18 We are getting into new fields now in special educa-
19 tion.
20 I was asked to review some projects they had approve
21 for Title III under the Elementary and Secondary Education
22 Act last year. Maybe some of you read it in one of the
23 Congressional Reports. I got hooked for one in special
24 education, innovative projects in special education.

25 Before I looked at those 30 projects or visited a

1 few, I said, "If I were to set up exemplary innovative programs
2 and needs, you know, what would I say?" I wanted to do a
3 little prophesying before I read those reports to see what
4 the people are doing, you know, asking for.

5 It came out about what I thought, you know --
6 emotionally disturbed, learning disabilities. These are the
7 two new fields that have hit the market in the last four or
8 five years.

9 And it's exactly what it turned out. How many pro-
10 jects did they ask for throughout the United States out of
11 millions of dollars for the deaf? One. Somebody wanted to go
12 down to pre-school and see if they can teach kids in the home.
13 It wasn't very exemplary or innovative.

14 How many in the blind? I think one. Somebody wanted
15 mobility training, but he said, "We have mobility training
16 at age 15." He wants to reduce it to 14 and 11 months, you
17 know, or this "great invention."

18 Is this all on the record?

19 But I mean this is it.

20 What did we have in mental retardation? Somebody in
21 Minnesota wants to set up a sheltered workshop. That's
22 "innovative" and "exemplary" or things like that.

23 But, you know, just about one thing here and there
24 in each of these fields.

25 But when it came to emotionally disturbed and

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learning disabilities, that was about 80 or 90 per cent of the money they asked for.

But how were they running? They were a little confused. One five-county area in one of the Southern States asked for a million dollars -- and got it -- to set up diagnostic remedial clinics. So they set up psychiatrists, psychologists, and social workers in one center. Then they had a satellite in each unit. Then they had a liaison officer in each school to get the kids to the satellite. And then they had remedial teachers, and they talked about mental retardation and crippled and deaf. They took the whole area of special education under the caption "Learning Disabilities."

I wonder how it's working really now, because they took in everything.

And, you know, under Title III there are a lot of projects for diagnostic and remedial programs in schools. I'll bet there are $10 or $15 million going into those schools -- maybe more than that. And what are they doing? I'm interested.

They asked me to review some of them this year, and I told them I was taking a leave of absence from that and everything else, though I am very interested to see what they really are doing in some of these centers and how do they define their area. Are they interested inthe mentally retarded, you know, under the caption of learning disabilities? Are they going to set up a program for the mentally retarded?

1 Do you know, Corrine?

2 DR. KASS: No, I don't.

3 DR. KIRK: But we have this sort of thing. We have

4 a lot of kids that are retarded educationally. They are not

5 up to grade in educational things. But we have a Title I to

6 do that. We can't take over the whole field of education

7 in special education. We have to limit ourselves to those

8 areas that require rather high specialized training and

9 remedial programs.

10 Now, the average teacher doesn't know exactly what

11 to do with, let's say, using the common term, the receptive

12 aphasic kid or the expressive aphasic kid in the language field.

13 They don't know how to start, how to go. You have to have

14 somebody who has some kind of training and some methodological

15 approaches of some sort to the development of speech in mute

16 kids, so to speak, even though they can hear and see.

17 So I say if we can define this in such a way not that

18 40 or 50 per cent of the kids-- Because we have other agencies

19 to handle the minor problems. What happens in most of these

20 remedial programs? I have seen them in schools. They are

21 disadvantaged kids. There's nothing wrong with the kids.

22 They're probably all right. When I say "nothing wrong," I

23 really mean it.

24 We had one experiment -- or two of them, as a matter

25 of fact. We took four-year-old kids from these public assistan

1 rolls, you know. Their average IQ was about 96. We took
2 another group with average IQ of 96. You say they are not
3 of normal intelligence because they are not 100, you know,
4 or something. Their average on the Binet is really 107 at
5 that age level to be average.

6 But, okay. You put them in a pre-school under cer-
7 tain kinds of specialized education. And this group goes up
8 17 points in IQ (indicating), and this group goes up 15 points
9 (indicating).

10 This group we send to kindergarten. After one year
11 they drop one point in the regular kindergarten.

12 This group we keep under specialized training, and
13 to my surprise they have gone up eight points. So we have
14 about 24 points' difference between four and six in IQ, with
15 an average IQ of 120 for these little disadvantaged kids.

16 Now, was there something wrong with those kids, or
17 is it, you know, cultural and environmental up to a certain
18 point?

19 So I say there's probably nothing wrong with the
20 kids themselves. They don't have developmental deficits.
21 And if we give them a fairly good environment and training
22 and schooling, they will probably move.

23 Because every form of intervention-- Take the
24 Montessori system. You get about a eight point increase.

25 Wherever you intervene with disadvantaged kids, you get a six-

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1 to eight-point increase in Binet IQ.

2 If you add something to that intervention, with some-

3 thing more programmed and systematic, you get higher acceler-

4 ation in mental development.

5 That's about all. I think our major problem is to

6 delineate this group (indicating at blackboard).

7 There are a lot of controversies. One controversy

8 is the differentiation of the learning case from the mentally

9 retarded, the deaf, the blind, the crippled. And that's

10 confusing when you are restricted to more professional groups.

11 But how are you going to define this group operationally in

12 such a way that parents and teachers and legislators and others

13 will understand it and the practitioner in the school will say,

14 "This child belongs here, but this child needs more specialized

15 training because of this"?

16 Thank you, Mike.

17 DR. MYKLEBUST: Thank you very much, Sam. As usual,

18 Dr. Kirk has given us a very basic statement of the many issues

19 involved.

20 And, of course, don't forget now you are going to have

21 time and opportunity to comment.

22 But, as you know from the agenda this morning, we have

23 asked some people to give us statements of issues, and we will

24 continue with that.

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25 Next we have Dr. Cass. As I said last night, it is

1 through her interest and cooperation that we could have this
2 conference. Because of her important responsibilities in her
3 office in the U.S. Office of Education, I asked Corrine if
4 she would give us some comments from that point of view. That
5 is why this has been listed as objectives for the conference --
6 to gradually try to get down to the basic issues, though Dr.
7 Kirk has already certainly gotten us very much involved in them.
8 Now, Corrinne, will you go ahead with any direction
9 then that you want with us?
10 DR. KASS: Thank you very much. I am very excited
11 about being able to exchange ideas with you.
12 What I would like to do is give three general objec-
13 tives, three questions which I hope will be answered or par-
14 tially answered in this conference. These are objectives
15 which Dr. Myklebust worded very well I feel.
16 Then I would like to expand on these by sharing
17 with you some of my experiences at the Office of Education to
18 see if we can note some interrelationships here.
19 The three objectives then are these:
20 One, what definition of a learning disability at
21 this time seems most advantageous and beneficial for national
22 purposes?
23 The second question is: What constitutes an inter-
24 related type of problem? That is, in the case of the deaf

25 blind, how much deafness and how much blindness should be

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present before a given child is most advantageously considered to fall within the category of the deaf blind?

Another example is that of a child who is emotionally disturbed and also has a learning disability such as dyslexia. How should these two involvements be defined in order to include the child under the category of the area of interrelated handicaps?

And the third question is: To what extent can centers of training meet the needs for trained personnel in the areas of learning disabilities and interrelated handicaps? In what ways should such training programs be augmented and oriented to more successfully meet the urgent demands of the nation at this time?

DR. KIRK: I wonder if you would repeat those? I didn't know you were going to put those questions. Just briefly.

DR. KASS: All right. One is: What is the definition of learning disability, or what definition of learning disability at this time seems most advantageous for national purposes?

Two, what constitues an interrelated type of problem? That is, in order for a child to be labeled as deaf blind, how much deafness, how much blindness should there be? How do we define an interrelated problem?

Third, to what extent can these training centers,

1 university training programs, be augmented and oriented to meet
2 the urgent demands of the nation at this time?

3 I should like to expand these and make some points
4 from my experience.

5 The first point I would like to make, or the first
6 question I should like to ask, is: Is there such a field? I
7 think we are going some basic assumptions. I think we can
8 assume that there is such a field as learning disabilities.
9 We do hear this term. We find that there is a great deal
10 of interest nation-wide.

11 You have heard about the mobs at a national confer-
12 ence such as the ACLD had in New York City. Many meetings
13 and conferences of the CEC are devoted to learning disabilities.
14 These are very popular.

15 The American Psychological Association in their next
16 meeting will devote one institute or one division meeting to
17 learning disabilities, a four-day-length institute.

18 So that many organizations, many professional groups
19 across the country, are assuming there is such a field. The
20 interest is great.

21 At the Office of education I have found that the
22 funding of the teacher-training programs is done under my
23 office, which is called "Interrelated Areas and Learning
24 Disorders," but since coming there I sense among my friends
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25 in the Government and in organizations such as CEC a shifting

1 about, whenever the word "learning disabilities" is mentioned,
2 and I have learned a new vocabulary at the Office of Educa-
3 tion.

4 Certain words are used rather often. I have heard
5 learning disabilities called the "sticky area," the "bucket
6 of worms." I have heard that we must "keep the lid on" this
7 area.

8 I have heard that we must "bomb out" learning dis-
9 abilities, that we must "get rid of the whole smear."

10 I'm exaggerating a bit, but these are words and
11 phrases which are very common.

12 It seems to me that this uneasy feeling, this de-
13 fensive laughter is pretty much centered in Washington, very
14 interestingly, and even to the extent that we find it among
15 the Washington universities, the special education departments
16 in some of the universities there.

17 So it seems to me that, while we find a basic
18 assumption generally that there is such a field, that there
19 are such children, we also find a feeling that this may be
20 the fad of the moment, that this may be a bandwagon which will
21 disappear, that this is something about which we are somewhat
22 embarrassed in special education.

23 The question then has to do with where this area
24 belongs. We find a great deal of overlap here in Washington
25 among the various agencies. You heard about Title III,

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1 supplementary services, under the Elementary and Secondary
2 Education Act. Many of these services have to do with learning
3 disabilities.

4 Our friends at the NINDB, the National Institute for
5 Neurological Diseases and blindness, are interested in this
6 area.

7 So I think, number one, we must ask ourselves the
8 question: Is there such a field? And what responsibility
9 do we in special education have toward this?

10 A second question we must ask is: How do we define
11 it?

12 I think, for the most part, professionals who are
13 doing work in what they call learning disabilities have a
14 professional definition. The concern nationally seems to
15 center around a national definition, a definition which
16 will give learning disabilities its place within special educa-
17 tion.

18 The Office of Interrelated Areas and Learning Dis-
19 abilities is an addition to the structure, the organizational
20 structure.

21 And I have found too since I came that wherever
22 anything within a bureaucracy is added, we have some unrest,
23 because it changes the organizational structure. It means
24 reallocation of funds. It means that the funds must now be
25 divided in one more way than previously done.

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1 So the hue and cry within this structure then is,
2 "Please define your area. Show us how you fit here. Show us
3 that you do, in the first place, and how you fit, so that we
4 will not be losing anything we already have."
5 At the moment the definition for handicapped childre
6 in the law lists a number of handicapping conditions, among
7 these mental retardation, deafness, blindness, crippled, and
8 the final phrase being "other health impaired which require
9 special education."
10 Since I have been asked so often to define the area
11 of learning disabilities, I have noted in some historical
12 research that none of the handicapping conditions are defined
13 within the law. There are no legal definitions of these handi-
14 capping conditions, nor is there a definition of special educa-
15 tion. So the only thing I can figure out is that everyone is
16 very comfortable with the usual definitions of mental retarda-
17 tion, deafness, blindness.
18 In other words, everyone takes it for granted and
19 makes the assumption that these are defined.
20 We have rather quantitative terms within which the
21 field works -- the IQ in mental retardation, the decibels in
22 the deaf, the number of feet one can see in the blind. But
23 there is not yet any quantitative way, any shorthand quanti-
24 tative way, of defining or describing learning disabilities.

25 So I think this question is a relevant one and one

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1 which forms one of our objectives. That is, how do we define
2 learning disabilities so that it is useful nationally, regard-
3 less of what we might do professionally or of the continuum
4 which we would use professionally?
5 A third issue or question is: What kind of services
6 are available for the children whom we call "learning dis-
7 abilities"? I think this forms probably a major portion of my
8 work, this very question, which comes from all parts of the
9 country, the question of what public school services are avail-
10 able for these children, or what private services.
11 Each time I get a rather sinking feeling, because it
12 is so difficult to answer these questions.
13 Most of the services I find for children with specific
14 learning disabilities are private services and very expensive,
15 extremely expensive.
16 The public school services are rare. There are some
17 communities which have a rather good coverage, but very few.
18 For the most part, parents and professionals must
19 look to private help. And included among the private services
20 are many of our so-called fads and panaceas.
21 We decry the fads and the panaceas, the "creepy-
22 crawly" methods, and so forth, and yet we must remember that
23 in many communities, in many cases, these are the only services
24 which are available.
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25 We find in this field I think a variety of labels

1 attached to these services, so that one private institution
2 might say it provides services for children with dyslexia and
3 brain injury and so forth. Another one might say, "We provide
4 services for children with learning disabilities" -- and
5 another one for language disorders.
6 All of this is very confusing to the clients, to
7 those who are looking for services.
8 In one sense it is rather amusing to get the various
9 phone calls and letters asking about services for children
10 who have been diagnosed as having "dislesia." People don't
11 know how to spell it. Or "dyslextic" children.
12 DR. BLAIR: "Asphasia." (Laughter)
13 DR. KASS: All types of labels. And this is be-
14 cause the fad and the panaceas I think form such a major por-
15 tion of the available services.
16 I think we might find the same thing in mental
17 retardation if the term "mental retardation" and the services
18 were not so widespread. We might, for example, find someone
19 suggesting that Hubert Humphrey's granddaughter has oligo-
20 phrenia, and they are searching the country for a special
21 school for oligophrenia.
22 The status term at this time in Texas, as I under-
23 stand it, is "dyslexia," and if you're anyone at all you must
24 have at least one child with dyslexia. Is that true?

25 DR. WOLFE: That's essentially correct.

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DR. KASS: I think in this field a lot of our tradition is centered about what Dr. Smigel called the European solo professional. We have certainly a number of Europeans who have worked out methods and procedures in this area, and we look to these as our solo professionals.

In addition, I think we have made a great deal of our intuitive geniuses in this field. We put our genius up on the platform in the foreground, and we say, "Show us what you can do. Strut your stuff. We'll watch you, and we'll thereby learn the secret. We'll learn what to do."

So many of our services, the available services, are few and far between, and many of these form the very sort of professional service which we decry.

We give a lot of lip service to interdisciplinary services, interdisciplinary cooperation. We brag about our multi-disciplinary approach. We call in all of these specialists. We listen to them. But I fear in many cases we are merely bringing our individual professional idiosyncracies with us. And, depending upon the group leader, the group dynamics, whichever philosophy or approach prevails depends on who is the strongest, who is the one who leads the group.

I like to caricature or characterize an interdisciplinary team-- This is exaggerated, to be sure, but I feel in many cases we are merely putting on an act in our interdisciplinary team.

Medicine I feel is "prestige happy." And we cater to this.

Psychology is "test happy." They use the battery of tests with which they are comfortable, and they interpret within the jargon of these test results.

Social workers are "gossipy." They like to fill us in with all of the environmental information, whether or not it may be relevant.

Speech therapists, occupational therapists, physical therapists I feel are "copy-cats." They like to think they are closely allied too, they identify with, the medical profession, so they like to use many of the same procedures.

Teachers I feel are "child-happy." They love to tell us all about children. And I think they do a lot of free associating on experiences and on what happens to children and to them, the interaction. Much of what they have to offer is irrelevant.

And special educators -- well, --

DR. KIRK: Careful! (Laughter)

DR. CASS: -- take your pick. Some of us are "label-happy," and some of us are "defensive."

And then the fourth question, one which I hope you will have time to get to -- I hope we won't spend so much time on the definition that we won't get to this -- is this: What is the need for personnel, and how do we train them?

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1 Actually, I think one of the responsibilities of
2 my office at the Office of Education should be to determine
3 the need, and the responsibility of the university training
4 programs should be to determine and to work out ways of
5 training personnel.

6 Trying to get an idea of the need for such personnel
7 is very difficult and is closely tied with the definition and
8 incidence of these children.

9 We are all well aware of the controversy and the
10 wide range here, the range of numbers of children. I should
11 hope that in our determination of the need for personnel that
12 we wouldn't be so narrow that we leave out a number of children
13 for whom then will grow up another group of pressure, of
14 lobbyists, pressure groups, another whole set of meetings to
15 determine how many of these children there are and whether
16 they fit within special education.

17 I also would hope that we are not so broad that we
18 cannot spell out the marketable skills, the services which will
19 be meaningful for the children whom we want to serve.

20 So the personnel training programs have to I think
21 consider at least five factors:

22 One is the core of courses, the basic foundation, the
23 basic knowledges. This was something that my panel of experts
24 discussed a great deal, and, in fact, suggested such a confer-
25 ence as this to work more definitively on core concept.

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This is true not only for learning disabilities but for multiple handicaps.

The question was raised: Is this just a matter of taking the curriculum for education of the blind, the curriculum for education of the deaf, the curriculum for the education of the mentally retarded and sort of putting these all together in one big curriculum, one which takes longer to go through? Or is there a way of combining and getting a core set of courses?

A second issue has to do with practicum experiences. That is, what kind of field experiences, internships, will the students have.

I have found in my visits to university training programs that these practicum experiences vary a great deal, take in public school work to clinic work. And the clinics also are varied.

There are speech clinics which are used, remedial reading clinics, psycho-educational clinics, psychological clinics, and so on.

Actually, I think for learning disabilities this is probably one of the main factors, one of the very important factors, in the education of personnel.

Third, I think an important issue is job description. Again closely tied in with definition, incidence, and need for personnel is the need for defining the qualities and the skill

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1 the technical skills or the professional skills, which will
2 make these personnel marketable and useful in the education
3 of children.
4 I found in my contact with university teacher train-
5 ing and students that there is a great deal of vagueness and
6 insecurity about job description. It seems very difficult to
7 pin individuals down, and graduate students often come up with
8 the weak response of, "Well, we're just graduate students."
9 However, as I travel around, I am much heartened and
10 feel very optimistic in the sense that I think the graduate
11 student in the areas of learning disabilities in multiple handi-
12 caps today feel very much a part of the growth of the profession
13 and are beginning to feel a responsibility in helping to set
14 forth the job description qualifications and skills.
15 A fourth issue I feel is very important is recruit-
16 ment. Unfortunately, our Federal funds are not being spent
17 for recruitment specifically, only secondarily in however the
18 universities themselves want to recruit. With spending some
19 funds for junior and senior year traineeships, I think perhaps
20 more work will be done in recruitment.
21 But we certainly have inherited in learning disabil-
22 ities a great many "retreads" -- you all know that term -- a
23 great many individuals coming from various fields who take
24 some additional training and enter the field.
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25 I feel we have done very little in the matter of

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1 recruitment at the high school and college level.

2 Finally, an issue is the evaluation of the training
3 programs. In other words, as Dr. Kirk used to say in the
4 courses I took, the proof of the pudding is in the eating.

5 And it seems to me that one of the very big issues
6 is: What are the effects of the training programs? Do these
7 people have skills which are peculiarly theirs? Do they add
8 to the educational team?

9 One of the very best ways to do this is individual
10 soul-searching, of course, which I think each university goes
11 through. The universit personnel I'm sure go through their
12 own evaluation, evaluation of their own program.

13 But another important part of this is the evaluations
14 and judgments which we can receive from consultants. I really
15 think that we don't use our experts -- we don't use consultants
16 -- to the fullest degree.

17 From personal experience I think this was brought
18 to my attention most forcibly with my first experience with
19 experts at the Office of Education who came to make decisions
20 on the proposals. And the thought occurred to me there that
21 this could very easily become wasted time on the part of the
22 experts if I as the implementer, the Office person, could not
23 carry out the suggestions and ideas in as high a level as
24 they were given.

25 In other words, if implications cannot be drawn and

recruitment at the high school and college level.

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In other words, if implications cannot be drawn and

implemented from various expert ideas, these individuals are wasting their time.

Probably the best example for us right now would be the example of having a sociologist come in, Dr. Smigel come in, and talk about his work and findings on growth of a profession. It's all very nice and interesting, but unless we really do see some of the implications and can pick and choose what is relevant to our field and our profession, it's just so much mental exercise.

Thank you.

DR. MYKLEBUST: Thank you very much, Corrine.

You just heard another excellent analysis of the problem. I have said to Corrine on several occasions I don't know how a young lady could learn so much in so short a time.

I have been around in some of the agencies in Washington for some years, but it is very rare in my experience to find someone who analyzes the problem as Corrine does. We appreciate it very much.

We will be getting into discussion of your statement of objectives.

Now, for the rest of the time this morning I should like to review then some of the tasks that we have.

We heard Dr. Smigel comment on, it seemed to me, some extremely pertinent questions in regard to professional growth, development, and shifts. In this connection I should

1 like to say that it seems to me that often in this discussion,
2 particularly in learning disabilities, there is a good deal of
3 dealing with the "straw man."

4 Actually the problem is there. It does exist. But
5 in terms now of Smigel's concept, we all come to it with many
6 different, varying mental sets and concepts. So there does be-
7 come the problem of dealing with the issues objectively and
8 in a straightforward manner, because it is very difficult for
9 us to get together on just what we want to do.

10 Now, this raises the question of definition. Defi-
11 nition for what? Sam has been touching on this, and so has
12 Corrine.

13 I would agree completely with the inference that our
14 first job should be a definition in terms of education, special
15 education, in terms of behavior. It is quite obvious, it seems
16 to me, that a definition for the field of let's say education,
17 meaning special education, is not necessarily going to be the
18 definition that will be accepted by other professional groups.

19 Now, some people find this very disturbing. I per-
20 sonally do not, because there are many precedents in the sense
21 that medical diagnoses of deafness, of blindness, of crippling
22 conditions, and so on, are not necessarily the ones the
23 educator uses. I think this would be true also of mental
24 deficiency.

25 I am always reminded of the very interesting

phenomenon that most idiots are diagnosed by behavioral criteria.
Yet today I should think it might be safe to assume that many
idiots are not diagnosable by the neurologist. He can't find
anything wrong with them or even through EEG.

No, we have behavioral criteria which work very well
here, and we use them. And, as a matter of fact, in these
instances medicine accepts them and goes along with them.

So I think our task is definition for education, and
not really to be greatly concerned as to whether such a defi-
nition would be generally applicable.

I have made the comment many times that each pro-
fession, for some of the reasons Smigel pointed out, has its
own criteria for defining phenomena. I think that is the way
it is going to be. I don't think they are going to necessarily
shift.

I think that, then, as educators, we have every
right to establish criteria, to establish a definition which
sets up criteria which may or may not be entirely acceptable
to other professional groups or organizations.

Now, I feel that Sam and Corrine were to some extent--
And I hope this is reflecting correctly here your feelings.
I think there was a bit of a plea involved, and there is for
me too, and the plea is along this line: That surely we,
representing handicapped children in special education, can
rise to the challenge which has come about here.

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1 In a way, then, we face a practical issue in this
2 country, and there is a great need for some action. This need
3 is now I believe so great that unless we can and do rise to the
4 challenge we really stand to lose a great deal for all special
5 education. And only our concern is for the children involved.
6 All of us can go out and make our way whether special education
7 really gets set back or not. That's no problem. The problem
8 is how to effectively meet the challenge so that the area
9 of learning disabilities is to come extent structured -- and
10 it is realized that it is structured -- so that these children
11 are effectively served.
12 But also, mind you, if we don't, we're in rather
13 great trouble with even our old standards here. I thought
14 Smigel is even a little frightening here, because, you see,
15 you can't assume that the old things will stand. If there is
16 one thing he is saying, it is you can't assume they are stand-
17 ing. These are shifting a great deal.
18 It seems to me that some revitalization, some basic
19 reconsideration, which I hope comes in tomorrow specifically,
20 like deaf children with learning disabilities that my friends
21 and colleagues in the field of the deaf are so greatly dis-
22 stressed by that it's alarming the whole field of deaf educa-
23 tion--- I hope you don't think I'm an alarmist, but I think
24 this is true. You find 25 to 45 per cent of these children

25 being referred to as having other problems. I think there is a

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1 similar kind of situation in the area of the blind.

2 Now, if we structure this area of learning disabil-
3 ities and then proceed with some implication for these other
4 areas, I think we have done something for the total area of
5 special education, and I mean all the handicapped children.

6 I'd like to, however, not leave it just at the level
7 of practical issues. As behavioral scientists I really believe
8 we have something to say. As a group of us right here, we
9 wouldn't agree on every dotted "i" and crossed "t" and comma,
10 but, as I will come back to in a moment, I don't think that's
11 important at all. But I think we will soon be agreeing sub-
12 stantially, as many of us do now, that the children we are
13 talking about are not learning by the usual assumptions at
14 least of the psychology of learning for the other groups.

15 I think that is the implication of Sam's "in-between"
16 group (indicating the blackboard).

17 Now, we have some six Ph.D. studies specifically
18 on this point. That is, when you do an analysis of how the
19 youngster with this type of dyslexia, this type of dyslexia,
20 this kind of other type of learning disability actually
21 learns, he doesn't learn according to the assumptions we are
22 making for the average child doing controlled studies now,
23 matched pairs, and using verbal learning techniques, and so on.
24 He simply isn't learning by the same processes. He is a dif-
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25 ferent youngster psychologically.

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1 And that's why I agree so completely that we are not
2 talking about these children where if you manipulate the envir-
3 onment and his experiences that's all you need. That's a dif-
4 ferent child.
5 I think then in the behavioral science criteria we
6 are on pretty safe ground when we do assume that these children
7 whom I think we must define as children with learning dis-
8 abilities without other involvements of deafness and so on,
9 are not learning by the usual set of assumptions that we bring
10 to the usual learning situation in a schoolroom. I don't think
11 they are learning this way.
12 Now, this is what I think becomes the core of your
13 training of people to work with them, et cetera.
14 There is a different psychology of learning, and I
15 think this is basic to the whole area of learning disabilities.
16 I think a basic science is developing, to some ex-
17 tent has developed, in this connection.
18 So that these youngsters then not only warrant identi-
19 fication and rescuing for practical reasons but for the very
20 basic reason that they need help in a sense that a modification
21 of what is expected from them -- that is, through techniques
22 and procedures -- is necessary for them to ever become -- to
23 ever actualize their real potential.
24 I don't think they are going to actualize their
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25 potential unless other than simple manipulation of environment

1 and so on is brought to their programs.

2 Now, it happens that I think it is safe to assume
3 that the true mentally retarded actualizes his potential in
4 somewhat different ways, that the deaf do, to some extent the
5 hard of hearing, that the blind do by different ways, to some
6 extent the partially sighted. Crippled, depending on what we
7 mean, may or may not -- may not shift the psychology of learn-
8 ing, that is, so that it is different from that assumed from
9 the normal found in terms of normal children.

10 Now, there are a few other things I believe, getting
11 more to the issues and the practical aspects.

12 It seems to me, as Sam was expressing, it is neces-
13 sary to come up with guidelines which do then set limits on
14 whom we wish to have classified in the category of learning
15 disabilities. One of the problems now is that -- and this is
16 exactly what you said, Sam -- that you can include every human
17 being under the rubric of learning disability. Because, re-
18 member, the person who doesn't have a learning disability is
19 simply one who hasn't been studied enough -- just like the
20 one who is healthy is only the one who hasn't been studied
21 enough, you see.

22 So, it is possible, of course, for every human being
23 to be included. Obviously we must set some limitations.

24 Now, one way to set limitations is to look at what
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25 we have. We have the retarded, the sensorially impaired, the

emotionally disturbed, the cerebral palsied, now the culturally deprived. We have these categories. And it is quite apparent that we do not all scientifically surely assume that the criteria here are well established.

I think Jo Taylor was indicating that 20/200 is not a good criterion. Not for you as a specialist and clinician, no. But for society it might be much better to leave it there so long as it's something-- It's something that has to be resolved, but something that is working.

I think that if we are going to be looking for something that every one of us doesn't find fault with, it simply doesn't exist. I think we should approach it this way. There is no such thing as an ideal solution. Believe me, there isn't.

This is my tenth year of serving on committees to define learning disabilities. I'm not going to be around to do it much longer. This is one of the most exciting I have ever been on -- this one right here.

It has been tried by interdisciplinary procedures with excellent people. It has been tried in all sorts of cut-down ways. "This person is troublesome; get that person off the committee." I have seen it work. It has been done over and over again.

Now, there is no ideal solution. Either we compromise and say, "No, it isn't going to work in all scientific

situations, it isn't going to work in all clinical situations, it doesn't fit every child" -- that's impossible -- unless we do, this conference will come up exactly as all of the others, and that is that we can't agree and there it is.

Now, there is overlap then from the normal to this population. There is overlap from this population to those in the deaf and the blind and so on. There are overlaps.

Now, may I suggest that to start with our problem isn't that. That's tomorrow. That's the multiply-handicapped.

To start with, the problem then seems to be: Can we come to sufficient agreement as to what it is that can operationally be set up as workable to include the dyslexics, other language handicapped children, but also children that can be defined as having non-verbal learning disabilities but are not then part of the other groups per se? They don't classify as mentally deficient, as deaf, as hard of hearing, as blind, as partially sighted, as emotionally disturbed.

Actually, this is, as I see it, the problem we face in definition.

Now, just a few words on approach to it which I have already tried to outline for you in some material I sent to you.

It seems to me that it is possible to say-- Well, I think we are saying -- could I state it this way -- I think we are saying in special education that there are deaf children

I know some people don't like the term. They don't want it at all. I like the term. I think some people are deaf. I think some people are blind. I have had people tell me right along there are no blind people. I think there are. I think there are mentally ill children, and I think there are mentally deficient children.

Now, let me state it like this: that if we are talking about children that simply fit in those other groups -- and if we are, we shouldn't be here at all then; they are taken care of -- and if we are just talking about children that overlap with these, there isn't really an area.

Obviously we are here because we think there is an area. And I think these are not the same children as those that are in the other areas.

So the first task then would be to prove that they don't belong in the other areas.

So you prove they have hearing. You prove they have vision. You prove they have intelligence. You prove they have certain integrity motorically and emotionally.

Now, this we refer to as the integrities that you have to demonstrate if he is going to be shown to have a learning disability which at least does not overlap with the other groups.

We have spent a long time working in ophthalmology trying to come up with a criterion which says, "If he has more

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than this kind, this extent of visual involvement, it will affect learning."

We have a publication on this coming out in a few months with our ophthalmologist. And, frankly, it says 20/40. It says if he has visual impairment of more than 20/40 it's going to retard him in learning. So that even though he is dyslexic he has two problems.

Now, this has been an attempt, which has covered now over a decade, to try to get criteria in some of these ways quantified, computerized, and so on, so that you have guidelines, we hope, at least for some purposes of education, and in this way begin to set limits for those that obviously overlap and those that do not.

Because there are children with learning disabilities, aren't there, without visual involvements and without these other involvements?

So if we could agree that these youngsters we are talking about are not primarily children who fit into the other categories-- I'm talking about the problems of definition, which is what I chose as an assignment here for myself simply this morning, to try to help clarify, with the excellent discussions we have had, as to what we will start right off with this afternoon.

Now, if we could agree that there are ways to establish that the child hears and sees and has other integrities

1 which are the type then that keep him out of the other groups,
2 then we have said this child doesn't fit in the categories of
3 special education that now exist.
4 But now we have just defined a normal child. Now we
5 have to, of course, define him as having a deficit of the kind
6 we call a learning deficit.
7 Then we are faced with: a deficit in learning what?
8 Well, it has been traditional to say he has a problem
9 in learning, he doesn't learn, if he doesn't achieve academic
10 learning, And that's still the basic one, of course, that
11 everyone is concerned about.
12 It is very obvious in the clinical sense -- I can
13 really testify to it -- there are many children with excellent
14 verbal integrities that learn beautifully in the academic
15 situation that have very serious non-verbal learning problems
16 which we call social perception problems. These children are
17 inclined towards delinquency and other kinds of difficulties
18 and are a very serious threat to themselves and to other
19 people.
20 Now, I am saying that we must define the deficit.
21 What is the deficit? And then we have to say how much of a
22 deficit are we looking for in order to call him a learning
23 disability.
24 Now, we have said he has integrity in basic ways,
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25 including intelligence, then, and so on, and taking the

criteria we want to establish for this. And then we say also, "But he doesn't learn normally. He has problems in learning."

All right. Learning what? And how much of a deficit in learning does he have?

It seems to me these are questions we face in coming to some definition of the child with a learning disability.

Now, let me state some of the issues that we obviously face.

I think Frank last night was implying, and I was prepared to listen for it-- I was hoping I was getting it straight, Frank, trying to understand. Because I was at a meeting of the National Convention of State Directors of Special Education in the past two weeks, and we were talking about this problem there. And Charlie Watson was there and someone else from California who slips my mind at the moment. And we got into this discussion. And I seemed to sense, Frank, that in California the trend is to include children with learning problems that they consider frankly emotional. This is my understanding.

You will have a good opportunity to talk about this this afternoon, Frank, as all of the rest of you will.

Now, it seems to me this leaves the door open for some very real problems.

Now, we are talking about a child, if he can't read and is emotionally disturbed, with a multiple involvement.

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1 Now, first of all, it seems to me then we need our norm groups.
2 Who are the deaf? Who are the hard of hearing? Who are the
3 blind? Who are the partially sighted? Who are the crippled?
4 Who are the emotionally disturbed? And then we add: Who are
5 the learning disabilities. This becomes the norm groups.
6 From this, then, we-- And I say right away, in terms
7 of clinical experience we have all had a great deal of, that
8 a child with a 70 IQ who has been deaf from birth is not the
9 same child as the 70 IQ with normal hearing. You don't just
10 add these up and come up with the same figures.
11 I learned this the hard way, making some very serious
12 mistakes as a psychologist in a State program for over a decade --
13 very serious mistakes.
14 This deaf child with a 70 IQ has much more of a prob-
15 lem than a normally hearing child with a 70 IQ.
16 We are going to have to come up here-- I don't know
17 how to do this. But certainly he doesn't rate at a 70 IQ for
18 many purposes, not when he is also deaf from early life.
19 Now, we have the norm groups. We still have the
20 multiple-handicapped criteria, which maybe have to be evolved
21 for a number of areas. But one question that we face is: Can
22 we agree on a group of learning disability children who are
23 not emotionally disturbed or do not have other problems either?
24 Now, does this mean that every State must look at

25 it in exactly the same way? Well, now, we are all aware in all

1 the States that no State looks at it exactly like any other
2 State. Every State varies. Here again we have gotten bogged
3 down in many sessions. We are not going to try to tell Cali-
4 fornia what to do. I have been through this.

5 DR. KIRK: It wouldn't do any good anyway. (Laughter)

6 DR. MYKLEBUST: Exactly.

7 Dr. Kirk started off something in this State a year
8 ago on a committee basis that has been followed up with a
9 vengeance during this past year, as you know, Sam. And what
10 I want to say about it is this:

11 One center in this State says: "But you can't define
12 us this way."

13 We say, "But, look, we're not trying to define you.
14 You go ahead and do what you want to. You have every right
15 to do what you want to. As a matter of fact, we'll fight for
16 your rights to do what you want to."

17 But it seems to me that we might, as we do in the
18 deaf and the blind and some of the others, at least get to-
19 gether on some general criteria that for some pretty critical
20 purposes now are needed, that for some pretty critical purposes
21 of guidelines are needed, or I think we are going to bog down
22 into some rather important, maybe serious consequences of
23 setback in various ways.

24 I realize then that-- Well, I personally feel that
25 we cannot assume that we are going to evolve an ideal solution

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for any one of us or for any one State or for the nation. That is, I believe, impossible at this time. I don't think it will ever be done. I think these things should be fluid and kept open in various ways.

Our desire here in this conference is rather different. It is that we might-- It's already delimited by not making it interdisciplinary. It was deliberate. It is simply this: Can we for special education agree on some guidelines that might be useful to people other than ourselves in any State anywhere? Is it possible for us to not feel that because we have a commitment to a certain way in which this should be done that it has to be done precisely in the way that I feel or that anyone else feels, but, rather, that we can compromise our total experience -- which, believe me, in this room today is considerable?

We all have a considerable experience to contribute to what is needed. That there is absolutely no question about.

And I think with some taking on of the discussions that we have had then this morning, sort of one at a time, issue by issue, it might be possible for us to come up with a fairly simple delimitation that might be quite workable as a matter of fact.

I said last night it seems to a lot of people today that the time is quite ready for this kind of agreement.

1 Please do not infer that what I have said this morn-
2 ing is in any sense an attempt to "brain-wash" any of you, to
3 get anyone to think in any particular manner. I have tried to,
4 as I think we all have this morning, to simply state some of
5 the problems and issues that have been suggested and have come
6 to our attention, not only for this conference but over the
7 years through other conferences.

8 I think, with that, if you have questions about this
9 afternoon we will be glad to have them. Otherwise we will
10 terminate for lunch. And what I want to say-- Do you have a
11 question, Corrine?

12 DR. KASS: No.

13 DR. MYKLEBUST: Sam?

14 DR. KIRK: No questions. I was trying to draw a
15 diagram of what you said, but -- (Laughter)

16 DR. MYKLEBUST: Good for you.

17 (Remarks off the record concerning luncheon arrange-
18 ments.)

19 DR. MYKLEBUST: We will congregate here again as soon
20 as we can after one o'clock.

21 (Whereupon, at 12:00 o'clock noon, the luncheon
22 recess was taken.)

23

24

25

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A F T E R N O O N   S E S S I O N

1:25 p.m.

DR. MYKLEBUST: I'm sure the others will be in in just a minute. I don't like to start until they come in, but perhaps they won't mind.

So now we do wish to have a discussion from all of you members of the Conference, and I would like someone to lead off.

DR. RIDGWAY: I have a question.

DR. MYKLEBUST: All right, Bob.

DR. RIDGWAY: When Corrine was talking about the objectives of the Conference, she mentioned that it would be helpful if we had a definition that would be beneficial for national purposes. I thought we might benefit from hearing what all was involved in this "national purpose" business.

DR. KASS: The national purpose would have to do with simply getting this term or this group of children within the definition of the law. I don't think the definition itself would be part of the law, or even the interpretation of it, but it would serve to get this into the definition.

MISS TAYLOR: Which is "other health problems."

DR. KASS: Which is under "other health impaired" at this point.

DR. SELZNICK: How was it given that particular designation -- "other health related problems"?

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1 DR. DENO: Somebody thought Sam said "physiological"
2 when he said "psychological."
3 DR. WOLFE: It was put in there because it couldn't
4 be put anywhere else.
5 DR. KIRK: When they wrote 88/164, Amendment to
6 85/926, which was for mentally retarded only, they tried to
7 define what they meant by handicapped children, and they said
8 deaf, blind, and so forth. They had one sentence in there for
9 speech correction, mostly because the speech people said,
10 "Look, we have got to have something designated specifically.
11 You don't just put us under any kind of category." So they
12 said "speech."
13 So you will find a sentence in there for speech
14 alone, even though the others are deaf, blind, et cetera.
15 Then they said "crippled." Somebody objected to
16 crippled alone, because what about epileptics and all the
17 other problems we talk about? So they said "crippled, health
18 and other problems that require special education," or some-
19 thing like that.
20 Am I right?
21 DR. KASS: "Or other health impaired."
22 DR. KIRK: "Or other health impaired that require
23 special education."
24 When we went in to try to write the rules and regu-

25 lations for it, then people said, "What about the brain-injured

kid? What about this? What about learning disabilities? What about it? Are we going to get anything?"

And I met with the lawyers on what this "other health" meant. And, of course, if you meet with lawyers, you might as well sit down and listen about what their interpretation is of the intent of Congress.

And finally I said, "Look, the profession means crippled, but there are some children who are tubercular or epileptic or all kinds. You can't really enumerate all the conditions that require some kind of specialized attention by schools outside of the ordinary."

And then we interpreted learning disabilities or that area because there was no special place for dyslectics or aphasics or something like that. So we said, "Well, we will say that this is health and other special problems."

So it brought it in to the regulations in some way that this could be in, and I think we subsidized four training programs that year and some research.

Now, it was put in as an interpretation. Because if you say "brain-injured" it is easier to interpret it that way. We didn't use the term "brain-injured," you see.

Now, it so happens that somebody comes in with a problem in aphasia, to do something with aphasics, and then the question is: Should it be under the section of speech or the section on crippled children and related problems?

1 DR. KASS: This is exactly the problem we run into.
2 DR. KIRK: All the time. So I say it depends on who
3 puts it in. If it is primarily a speech pathologist that puts
4 in the request for speech, have it under the speech people. If
5 it is from an educator doing work in remedial work, we will put
6 it under this other problem. So it is that loose.
7 Now, the looseness of the law then causes a lot of
8 difficulties, and people have tried to introduce -- with deaf,
9 blind, crippled -- learning disabilities or something like that.
10 It has so far never been accepted by Congress, and that's why
11 Morse, you know, quoted me as saying it's physiological and
12 therefore it could come under health and other impaired, so
13 why fool around with another term when we have already got it,
14 you see.
15 MISS TAYLOR: An interesting sidelight here I would
16 like to bring in is that the Library of Congress has for years
17 had a library for the blind, you know, and there was so much
18 pressure from parents and schools working with children with
19 learning disabilities, and also others, elderly persons, that
20 the bill was revised, and it has become the library for the
21 blind and physically handicapped.
22 And they have immediately considered that because
23 the learning disabilities have a brain dysfunction or neuro-
24 logical problem they are eligible.
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25 So that it is not only in the Office of Education

1 that we have these same problems and interpretations.

2 DR. MYKLEBUST: Yes.

3 All right. Any other questions or comments?

4 DR. RIDGWAY: Are there other phases of what you --

5 DR. KASS: Did that answer it? I believe I did say

6 legally none of the conditions are defined. It seems to me that

7 we are being asked to define this for national purposes for

8 this reason -- that it is either to be separately listed or

9 to be given some place under other health impairment. I mean to

10 sort of make that legal.

11 DR. MYKLEBUST: Please check me on this, Corrine, if

12 I am wrong. You know much more about this than I. But it would

13 seem to me one thing that was in mind here too was that it is

14 increasingly difficult for your panels to appraise requests

15 on a national basis. So I think one of the national purposes

16 would be that it might serve as a guideline for government

17 agencies, in this case mainly the Office of Education, for pur-

18 poses of appraising requests and programs.

19 Would that be a fair statement?

20 DR. KASS: Yes.

21 DR. BLAIR: Can we start to work on the definition

22 now?

23 DR. MYKLEBUST: Sure. Go ahead, Frank.

24 DR. BLAIR: Two or three of us I guess here were at

25 the conference at Kansas last fall and went through some of

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these same experiences. I guess we learned something from it. Or did we? But we found really we weren't accomplishing very much until the very last hour of the two-day conference.

So it suggested to us that we should next time, if it should happen, go right to bat and try to pin down this definition.

Some of us were talking at lunch about how we might approach this, and it seems that if one looks at several definitions which now exist we see common elements that run through them.

It seems likely that we shouldn't bother trying to repeat the work of other committees necessarily but to build on what we have. And it shouldn't take us too long to come up with something.

I have just been jotting down here, as we were talking, four points that I think run through some of these definitions.

The first one would be we are talking about youngsters with normal IQ or above.

Second, we are talking about children with learning and/or behavioral manifestations of a particular type or types.

Third, that these are deviations resulting from certain --

DR. KIRK: What was the second one?

DR. BLAIR: The second one was we are talking about

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1 learning and/or behavioral manifestations of various types.

2 Third, we are concerned here that these manifesta-
3 tions derived from deviations or dysfunctions of the central
4 nervous system.

5 And the fourth would be that these manifestations in
6 learning and behavior do not primarily result from sensory de-
7 fects, generalized retardation, or emotional disturbance.

8 Now, there may be possibly a fifth common point, may-
9 be a sixth, even, but it seems to me these are the four that
10 I see running through most of the definitions that we have.

11 I think that beyond this I would say perhaps problems
12 arising in terms of what specifically are the manifestations
13 we are talking about. What are the learning and behavioral
14 manifestations? And then how do we refer to these? In other
15 words, what terminologies do we use? What terminologies do
16 we avoid in order to bring about communication and in order
17 to avoid emotional overtones that I think so often have inter-
18 rupted or disrupted our work?

19 DR. MYKLEBUST: All right.

20 DR. CHALFANT: I have something to add to the remarks.
21 I did an analysis of the definitions and some of the character-
22 istics. Some of the terms concerning the behavioral manifesta-
23 tions or problems are listed, such as disorders in one or
24 more of the processes of thinking, conceptualization, learning,
25 memory, speech, language, attention, perception, emotional

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behavior, neuromuscular motor coordination, reading, writing, arithmetic, discrepancies between intellectual achievement potential and achievement level.

Now, when you look at a lot of the characteristics that are included in the various definitions, many of these things could be considered as disorders of central processes as one method of classification or grouping the kind of learning or behavioral disorders.

DR. MYKLEBUST: All right. Let's go right on here. Who else is ready? Bill? Harrie? Is anybody else ready?

DR. SELZNICK: I'm just asking myself a question on number one, normal IQ.

DR. BLAIR: Or above.

DR. SELZNICK: Or above. I wonder if we are not falling into the trap of the past where we are assigning value to an imperfect instrument in assessing youngsters and their suggested learning potential.

I think we ought to relate to what is our specific assignment. And if it is educational, are the tools that we are using to help locate children sufficiently definitive for the purposes for which we are using them?

I go back to what Sam put on the board when he talked about the change in scores identified in certain specific children. And yet we used an instrument to which we assigned what we thought were true values, and yet we found

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1 they weren't true values and may have resulted in mislocation
2 of children. I wouldn't say that that happened in this case
3 because the children did obtain release on native abilities.

4 I think we go back to saying: What should schools do
5 for children? I think that schools have a responsibility to
6 organize a variety of learning opportunities. And rather than
7 to specifically pinpoint an IQ as a basis for location of
8 children, we use that as one of the means for determining the
9 program from which a child can benefit along with other means,
10 and then readjust the child in a location from which he can
11 benefit at that point in his development, rather than assigning
12 true values.

13 I think we have gotten into traps from which we have
14 never escaped.

15 DR. BLAIR: Harrie, I think this is what I meant when
16 I said let's avoid the use of terms emotionally-laden. I
17 didn't mean IQ. I meant intellectual potential. And if this
18 is what is bothersome, we could say normal or above intellec-
19 tual potential.

20 This is basic. If there is a beast called learning
21 disabilities, then I would be of the opinion that this is at the
22 heart of it. And I would agree with you in terms of the
23 sacredness of the IQ as a score.

24 DR. RIDGWAY: Why is No. 1 not covered in No. 4?

25 DR. BLAIR: Well, I think perhaps this simply is a

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1 little more explicit aspect of the definition to point out --

2 DR. RIDGWAY: You wouldn't think a youngster with IQ

3 of 85 who would not be eligible for most programs of mental

4 retardation --

5 DR. BLAIR: It seems to me this brings us close to

6 the whole matter of overlap, and I would agree we have these

7 problems. I guess the concern again would be whether there

8 is something discrete here that we can look at, at least in the

9 first instance.

10 Can we look at something discrete? And then I think

11 this matter does spill over into the business of the overlap-

12 ping. How far down do you go before you reach the retardate

13 and so on?

14 MISS TAYLOR: Would you give your fourth point again?

15 DR. BLAIR: Not related to other major handicaps.

16 DR. MYKLEBUST: Okay.

17 MISS TAYLOR: That wasn't the way you worded it be-

18 fore.

19 DR. BLAIR: No, it isn't. Please don't take this.

20 This is just scribbled out here.

21 MISS TAYLOR: I think this has to do with what is

22 going on.

23 DR. BLAIR: I think the hammering out of the language

24 is something that needs to come. I think we have to agree

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25 on the --

1 DR. MYKLEBUST: Okay, Jim.

2 DR. CHALFANT: In developing any definition, every-
3 body has a number of points they want to include in that defi-
4 nition. I was wondering if it might be helpful just to list
5 on the board the major points that everyone feels should be in
6 a definition. Then we can very quickly identify where there is
7 agreement and then focus on those areas where there might be
8 some differences of opinion.

9 DR. MYKLEBUST: Do you like this approach? Shall we
10 have Jim take the slate and everyone put in what they think
11 should be in it and see what we come up with? Shall we try
12 that?

13 DR. BLAIR: I think we should.

14 DR. MYKLEBUST: All right, Jim. Why don't we see
15 what we can do with this?

16 DR. DENO: Before we start, it seems to me in all
17 the talking --

18 DR. CHALFANT: I can start off with --

19 DR. MYKLEBUST: Just a moment here. Now, Evelyn, go
20 ahead.

21 DR. DENO: Nobody specifically mentioned something
22 which I guess we take for granted. Maybe it's in the defini-
23 tion of disorder. But you mentioned it about assumptions
24 about the psychological learning principles or something

25 like this.

1 But actually the first criterion here is that this
2 youngster is not learning by the assumptions of a reasonable,
3 regular program. Now this is what is emerges.
4 DR. MYKLEBUST: That's right.
5 DR. DENO: That may not be real critical in what is
6 needed in Washington. And partly what gets needed in Washing-
7 ton is by virtue of the fact that we haven't historically de-
8 fined all these handicaps medically and as health kinds of
9 problems.
10 Now we are switching over onto a track where we are
11 quite specifically even by the terminology we are using cast-
12 ing it in an educational frame of reference.
13 And I am very empathic with Harrie here on this
14 point, because the educator can't exclude any kids. And we
15 have this tendency to write exclusive definitions so that they
16 fit the historical patterns of medical definitions, and I know
17 we aren't going to get around this.
18 We have to somehow reconcile this and deal with it,
19 but it is kind of central in our problem, and maybe that should
20 be right at the top where, first of all, we are dealing with
21 children whose needs cannot be met by the assumptions of the
22 standard program, and that carries a lot of implications.
23 DR. MYKLEBUST: Yes.
24 DR. DENO: Because this can change over time. Our
25 regular program sets up certain kinds of expectancies and

demands now simply because of the way information is presented or something.

Given some change in the mechanics of this, this has got to be sliding here.

DR. MYKLEBUST: Yes. And it is possible I should think that this could be made one of these -- that these assumptions here must be shifted.

Why don't you try to formulate that? I should think that would be very useful in the setting that you are going to set up here. It might even be a preamble. I don't know.

But probably all of us would want this. I'm just guessing. Perhaps all of us would like to have this kind of statement where we make the assumption these youngsters do need other than regular classroom kind of teaching, and so on.

DR. DENO: Maybe, as you say, that can be a preamble that sort of states to us in an educational frame of reference this is what constitutes disorder and atypicality.

DR. MYKLEBUST: Could we keep in mind that there is a real possibility that we will need some preamble to state even what the definition is aiming at, what we hope that it might achieve. And I think this could be included in that if we want to do this.

Anything else? Shall we let Jim get started?

MISS TAYLOR: I have another point.

DR. MYKLEBUST: All right, Jo.

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1 MISS TAYLOR: I'd like to go back to the point about
2 normal intellectual potential or above. It seems to me that
3 this is taken care of in the fourth point and that we must recog-
4 nize that there may be some persons of below average who also
5 have, due to other causes, a learning disability.
6 If you put in the definition of children with learn-
7 ing disability this statement that you start with, you are then
8 not putting yourself in a position of defining the child with
9 the learning disability.
10 DR. MYKLEBUST: Well, let's see where we are here.
11 Go ahead, Phil.
12 DR. HATLEN: I was going to say: Have you really
13 changed these four points or what you are aiming at if you
14 eliminate 1 and 4?
15 MISS TAYLOR: I think you have to have 1 and 4, be-
16 cause this is indicating that the learning problems are not due
17 to the other handicaps.
18 I mean there are learning problems or learning dis-
19 abilities due to deafness or something of this sort, but this
20 is not the type of disability we are speaking of in this defi-
21 nition.
22 DR. MYKLEBUST: That's correct.
23 DR. HATLEN: Yes.
24 DR. MYKLEBUST: You know, I don't think we are to-

25 gether. My point 4 doesn't jibe with what you are saying here

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1 at all. So I took it down wrong or something.

2 If we are going to discuss these points, I think we

3 should get them up there on the board. I don't think we are

4 talking about the same thing.

5 DR. BLAIR: Good point.

6 DR. MYKLEBUST: Well, if it's all right, then, let's

7 see what-- If we are going to take these points up -- which

8 may be a little bit premature; I'm not sure -- let's put up

9 what we have here if we are going to talk about it.

10 DR. KIRK: What they have really said, Jim, on No. 1

11 is that learning disability is assumed to have normal or poten-

12 tially normal intelligence and intact sensory and motor abil-

13 ities. I mean that's stating it.

14 DR. MYKLEBUST: That's correct.

15 DR. KIRK: Intact.

16 DR. SELZNICK: Would you say "intact" or "minimally

17 affected"?

18 DR. KIRK: Or say "minimally affected sensory."

19 DR. MYKLEBUST: Well, the terminology here could be --

20 DR. KIRK: We are excluding --

21 DR. BLAIR: I'd like to suggest I think hammering

22 out of the language is secondary gere.

23 DR. MYKLEBUST: Yes. The term "intact" has ad-

24 vantages, and so on. You define what you mean by "intact"

25 then.

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1 DR. BLAIR: I think it's the substance we are after
2 at the moment.
3 DR. MYKLEBUST: Depending on your criteria for those
4 groups.
5 I do think we perhaps should try to get up what we
6 have.
7 DR. KIRK: Put "potentially normal intelligence."
8 That gets around that block.
9 DR. MYKLEBUST: All right.
10 DR. CHALFANT: Potentially normal intelligence.
11 Then there was the second point that Frank made con-
12 cerning behavioral manifestations. How did you word that?
13 DR. BLAIR: Learning and/or behavioral manifestations
14 DR. MYKLEBUST: Does anyone care to comment while
15 this is going on here?
16 DR. FLIEGLER: If I might suggest, Mike, perhaps to
17 make it a little simpler -- and I'm not trying to divert the
18 group --
19 DR. MYKLEBUST: Go ahead.
20 DR. FLIEGLER: I am suggesting what Jim read and
21 what Sam talked about may very well be our initial cue, and
22 that is attempting to describe these youngsters, who they are
23 and attributes they have and attributes we would assume that
24 they do not have to some degree, rather than -- and this is
25 what Evelyn was getting at -- a definition of being exclusive.

1 It may well be if we describe the youngsters as
2 we see them in terms of certain attributes, our definition may
3 then fall in line. I don't know.
4 DR. MYKLEBUST: Don't you think this is descriptive,
5 Lou? You're saying what they ought to have.
6 DR. FLIEGLER: Well, No. 2, you see-- 1 is --
7 DR. CHALFANT: This could be broken down.
8 DR. MYKLEBUST: That No. 2 is difficult. That would
9 have to be broken down a good deal.
10 DR. FLIEGLER: Right.
11 DR. MYKLEBUST: Yes. All right. I see what you
12 mean.
13 DR. FLIEGLER: I didn't mean to interrupt you.
14 DR. CHALFANT: Oh, no.
15 DR. FLIEGLER: I think the criteria which have been
16 established here certainly will have to have qualifying
17 verbiage.
18 DR. MYKLEBUST: That's right. In this initial kind
19 of discussion period here, perhaps if we do bring in some of
20 the things other committees have done, it might be a little
21 helpful.
22 For example, an attempt was made long ago to take
23 No. 2 and describe these children by behavioral characteristics
24 and I am positive we will never get anywhere with it. It has
25 been done. It has been tried. You can't get any agreement

1 about it. It overlaps with mental illness and all sorts of
2 things.

3 So to say that he is perseverative, distractible, et
4 cetera, simply does not come out at all. Other committees have
5 done it, tried it, even written it up.

6 Now, some of these children do have such manifesta-
7 tions. Many of them don't, as I am sure we all know. So it
8 isn't really definitive.

9 I don't think that's quite what Frank had in mind
10 up here.

11 DR. WOLFE: You really mean deficits, don't you,
12 rather than manifestations?

13 DR. BLAIR: It seems to me they are manifestations.

14 DR. WOLFE: You could have positive things --

15 DR. BLAIR: Manifestation is that which shows itself
16 in a child. That's all.

17 DR. WOLFE: That's true. But this is true in all --

18 DR. MYKLEBUST: Excuse me. Jim, go ahead.

19 DR. CHALFANT: If you have a deficiency in your cen-
20 tral processes, this would be reflected then in academic
21 learning or in behavior in some way. So it is really the dif-
22 ference between process and product. With deficient central
23 processes, therefore, the product would be inability to learn
24 academically and behavioral manifestations.

25 DR. BLAIR: Again I think we are concerned about our

1 language at the moment, and I don't know that we should be.
2 I guess we have to communicate, but at the same time --

3 DR. MYKLEBUST: Yes.

4 DR. BLAIR: The third one, Jim, was dysfunctions --
5 maybe we should add either demonstrable or presumed dysfunc-
6 tions -- of the central nervous system.

7 DR. CHALFANT: Which?

8 DR. BLAIR: Both.

9 DR. CHALFANT: All right.

10 DR. BLAIR: I think Dr. Myklebust's paper describes
11 this very well.

12 DR. SELZNICK: Then we have to ask ourselves: Who is
13 going to identify this dysfunction, and are we assigning the
14 responsibility or a role in the selection process to another
15 discipline, the neurologist, for example? Isn't that taking
16 it out of the realm of education?

17 DR. MYKLEBUST: Well, I will simply say at this
18 point it isn't what I mean at all by taking it out of education
19 But what do the rest of you think? It wouldn't be what I
20 mean, Harrie, no.

21 DR. SELZNICK: It has to be said in such manner that
22 the neurologist doesn't say, "Well, even the educators are
23 telling me this is the area in which I should have primary
24 responsibility."

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25 DR. MYKLEBUST: That's right. This has to be avoided

1 I agree completely.

2 DR. RIDGWAY: Perhaps the fifth or sixth points up
3 here will get at what is meant by No. 3 in another way that
4 won't bring in this point.

5 DR. MYKLEBUST: Yes.

6 DR. CHALFANT: Maybe we should just list them.

7 DR. MYKLEBUST: Go ahead.

8 DR. CHALFANT: Then we can talk about it.

9 DR. MYKLEBUST: Good idea. Let's do it.

10 DR. CHALFANT: The next one was "not sensory depriva-
11 tion."

12 DR. BLAIR: Not primarily resulting from.

13 DR. CHALFANT: This is the negative component then.
14 Are we going to call this sensory involvement?

15 DR. BLAIR: I don't think it matters at this point.

16 DR. CHALFANT: Not primarily sensory problems then.

17 DR. RIDGWAY: There is another part to that.

18 DR. BLAIR: Generalized retardation and emotional
19 disturbance.

20 DR. CHALFANT: Yes.

21 DR. HEWETT: It's assumed in this approach that all
22 exceptional children have learning disorders, but there is a
23 group that have learning disabilities that have a neurological
24 base, and everybody else who has a learning disorder can be
25 placed in some other existing category? This is the assumption

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1 in all this?

2 DR. MYKLEBUST: Yes, I would think that's quite basic

3 to the discussion as I understand it, Frank. As Sam said, it

4 could be genetic, neurochemical or biochemical or anything.

5 It's not brain damage and neurological in that sense as I

6 think of it.

7 DR. CHALFANT: Do you want to put in instructional

8 or cultural factors with the rest of this or not?

9 DR. BLAIR: Well, possibly you could add cultural.

10 DR. HEWETT: Deprivational really. The kid hasn't

11 been in school.

12 DR. RIDGWAY: Isn't this implied in all of the areas

13 of special education -- I mean as written into the law as you

14 were quoting it?

15 DR. MYKLEBUST: I'm just reacting here. I want every-

16 one else to react. It is my opinion that that is true, that

17 you don't have to spell that out here. It does assume oppor-

18 tunity. It is another one of the assumptions, Frank. It

19 assumes opportunity for learning.

20 DR. RIDGWAY: That he hasn't been locked up in a

21 closet someplace or chained to a bedpost.

22 DR. MYKLEBUST: That's right -- which is a different

23 problem on this assumption all the way.

24 DR. CHALFANT: Then there are --

25 DR. KIRK: When you say that he has a behavioral

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1 manifestation, that he has to have some aberration of behavior,
2 and then you exclude it in No. 4 when you put emotional dis-
3 turbance. They contradict each other.

4 DR. BLAIR: Only if --

5 DR. KIRK: In one place you say behavior manifesta-
6 tion. In the other one you say emotional disturbance, which
7 is a behavioral manifestation.

8 DR. HEWETT: So is retardation a behavioral manifesta-
9 tion. Isn't it a behavioral manifestation?

10 DR. KIRK: In a sense, yes.

11 DR. MYKLEBUST: The terminology is overlapping here
12 and would have to be worked out. I think this could be inter-
13 preted as inconsistent.

14 DR. HEWETT: What you mean in No. 2 is somehow we
15 can get some evidence it exists. We can see something or
16 measure something.

17 DR. MYKLEBUST: I would think that's what you mean,
18 Frank.

19 DR. BLAIR: Well, I think this is really one of the
20 major problems of defining it -- is this overlap, presumed or
21 real, between emotional disturbance and certain of these be-
22 havioral manifestations that you indicate, Mike, quite
23 accurately may occur with brain injury and so on, and it
24 seems to me we have to include in this some of these behaviors
25 that we see in children that, of course, may stand in the way

1 learning.

2 Now, maybe on that basis we could eliminate it and say

3 this behavior they have, this distractibility, and so on, we

4 see in many of these, stands in the way of learning as Strauss

5 said many years ago.

6 DR. KASS: Couldn't we call it performance manifesta-

7 tions then to make it more --

8 DR. BLAIR: Possibly this would be less confusing.

9 DR. MYKLEBUST: That's a real help, I think. I think

10 we are getting to what Bill said, too. I really think we are

11 talking about what he doesn't learn. It's deficits I think.

12 That's performance, you see.

13 DR. RIDGWAY: You mentioned that in one of the points

14 you had, Jim, so if you put yours up there you might make that

15 clear.

16 DR. MYKLEBUST: Go ahead.

17 DR. CHALFANT: The point I raised? I think that it's

18 deficit in one or more of the central processes (writing as

19 No. 5 on the board).

20 DR. KASS: Isn't that the same as No. 3?

21 DR. MYKLEBUST: Somebody has sort of lost you here,

22 Jim. We don't know what you mean. Will you spell it out for

23 us?

24 DR. CHALFANT: The central nervous system, brain,

25 brain stem and spinal column. If you have a lesion you may

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1 have paralysis. By "central process," this would be in the
2 brain proper such as revisualization, auditory fusion.

3 The central process, you know, is not a function of
4 the brain stem or the spinal column. It's what goes --

5 DR. SELZNICK: I'm afraid of that.

6 DR. BLAIR: I would tend to include those under No. 2,
7 Jim, what you have been stating. I think there is --

8 DR. CHALFANT: Yes, this would also fit under here.

9 DR. BLAIR: I think on the face of it, No. 3 and
10 No. 5 appear to be identical.

11 DR. RIDGWAY: If we throw all our ideas in, we're
12 going to find lots of things that are identical. Then you can
13 pull them out.

14 DR. KIRK: Let's list them down.

15 DR. CHALFANT: Another idea that goes along with this
16 in a lot of definitions is the discrepancy concept. You have
17 the deficit, one or more-- It's sort of implied here, but
18 Gallagher defines it in terms of developmental imbalances.
19 Dr. Kirk has a definition of discrepancies in functioning.

20 DR. SELZNICK: What about disorientation in an educa-
21 tional environment?

22 DR. CHALFANT: What was that?

23 DR. SELZNICK: Disorientation.

24 DR. KIRK: What Miss Deno was talking about, mal-

25 adaptation to ordinary educational environment. They can't

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1 learn.

2 DR. SELZNICK: In the educational environment. That's

3 not saying it exactly, but it's the basic front.

4 (Reporter's note: Point No. 6 listed on the board as

5 "Disorientation in the Educational Environment.")

6 DR. MYKLEBUST: Bill?

7 DR. WOLFE: I don't know how to say this, and I'm

8 not being facetious when I do say it, but I have read a number

9 of definitions, and I am interested to find out what your

10 reaction is to this. Where does poor teaching fit into this

11 thing?

12 DR. MYKLEBUST: Well, could I --

13 DR. HEWETT: It doesn't, you see.

14 DR. WOLFE: I think this is basic, so very basic.

15 DR. HEWETT: This whole definition says it is the

16 child failure.

17 DR. WOLFE: That's right.

18 DR. HEWETT: This is one of the critical issues.

19 DR. WOLFE: I would guess there are more kids

20 labeled learning disabilities who are resultants of poor teach-

21 ing than there are children who are resultants of this we are

22 putting on the board.

23 DR. HEWETT: Don't you think once a teacher can get

24 off the hook with a definition like this, they are not going

25 to be as concerned with teaching if they can say, "There's

1 something wrong with the kid's brain; it's not my problem"?

2 This is what IQ scores have done. They have stood

3 in our way. And this is exactly what this definition is going

4 to do with some teachers.

5 DR. CHALFANT: Do you do something different with a

6 kid like this than you do with a kid that doesn't --

7 DR. WOLFE: And along with that, in the very same

8 breath, this is not a cultural thing in the sense that we

9 use "disadvantaged" and the like, but I'm thinking about the

10 child who is from a high socioeconomic home but who is quite

11 disadvantaged educationally.

12 DR. MYKLEBUST: We all know these, but --

13 DR. WOLFE: Surely we do. But are we recognizing

14 them in the definition?

15 DR. MYKLEBUST: No, it's entirely the intention as

16 far as my comments are concerned to exclude them. You're

17 talking about problems in the whole educational system.

18 DR. WOLFE: I indeed am.

19 DR. HEWETT: If we compound them, if they are com-

20 pounded with something that is supposed to bring clarificatio

21 DR. MYKLEBUST: You might view it that way. I think

22 the whole assumption here is though that there is a child

23 with a learning problem that is not the teacher's and not

24 the culture's basically, and so on.

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25 And this other problem you are concerned about

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1 I don't think is the one that we are facing now, not nationally
2 or locally or in State legislatures, or so on.
3 I think we have got to worry about poor teachers,
4 ladies and gentlemen, believe me, but I don't think it's here.
5 I think this is quite a different issue.
6 We are talking about handicapped children, not handi-
7 capped teachers.
8 Now, I am just trying to keep us on something that
9 may be resolvable. If we can avoid the issue of what is wrong
10 with the school system-- Believe me, it has been tried a lot
11 of times with committees, and this won't work.
12 MISS TAYLOR: Why couldn't we put it there where we
13 say "do not arise from" and put "sensory, educational or cul-
14 tural deprivation"? That eliminates those other things that
15 might be confused with this.
16 DR. MYKLEBUST: I thought this all would be in the
17 preamble, all said very clearly, that we are not talking about
18 these children. I thought that would be stated very clearly.
19 DR. RIDGWAY: This is taken care of anyway in No. 5,
20 because if a youngster does not read but has no problems with
21 his central processes, then this is not a learning disability
22 case.
23 If the youngster can do all of the things that are
24 implied in No. 5, then you have got a teaching problem rather
25 than a problem for special education.

DR. HEWETT: In both 4 and 5 there is a colossal margin for error in terms of deciding when we can rule out thi and that. This is the problem.

It sounds kind of neat when we just put it down. Bu do you realize the margin for error in deciding when a child is not a motivational problem?

DR. MYKLEBUST: What is the margin for deciding a child is mentally retarded, deaf, or blind?

DR. HEWETT: I'm talking about mostly emotional disturbance and motivation.

DR. MYKLEBUST: In emotional disturbance there is a bit more of a problem I would concede.

DR. HEWETT: I would say there is no way you ever rule out emotional disturbance and motivational problems.

DR. MYKLEBUST: I thought this was your position. I think there are people who might have another position, in that you can. I would be one of them.

I think our clinical judgments on these things can be very accurate. Clinical judgment of various other people can be very accurate. So I wouldn't take the position that is hopeless.

DR. BLAIR: I would agree with this point. I think we have enough clinical evidence to suggest we have a population we can point to and say, "Here they are, and, by golly, they are not emotionally disturbed primarily."

1 Now, many of them have certain manifestations that
2 might be considered emotional, but, by God, they are learning
3 disabilities.
4 MISS TAYLOR: For whom is this definition being
5 written?
6 MR. MYKLEBUST: Office of Education.
7 MISS TAYLOR: Do you think that throughout the coun-
8 try there are those who will not be confused unless you are
9 pretty specific?
10 DR. MYKLEBUST: Well, again, I think, you see, we are
11 just raising questions that always are there. Obviously
12 people can mislead and misread. They will do that with any-
13 thing you do. So we can't be sure everybody is going to under-
14 stand it exactly.
15 That's what I mean by "slight progress." After all,
16 if mankind makes any progress at all, it's pretty slight, you
17 know. And if we make a little progress, I think that's help-
18 ful.
19 I again wouldn't take the position that because
20 people are going to misinterpret something we do that there-
21 fore it isn't useful.
22 MISS TAYLOR: No. I'm sorry. I didn't make myself
23 clear. My point is that there may be some who may not be able
24 to differentiate, who are in numerous special education
25 programs around the country.

DR. MYKLEBUST: I simply have to say that of course there are. There are in anything you do.

I see more deaf blind children misgrouped than any one category in ratio of any group I have ever seen. But still we do it every day.

DR. BLAIR: It had been my intention earlier -- for some reason I thought better of it; I don't know why -- to suggest that the Task Force I definition might be a thing that we would look at as a model. It seems to me as we develop this, again, many of the points that we have placed on the board are in this definition. And while I think it would mean some revision, it might be a model we should investigate.

DR. KIRK: Would you remind me of their definition?

DR. MYKLEBUST: Let's have it.

DR. BLAIR: I have it before me. You remember the term they used, "minimal brain dysfunction syndrome."

"The term 'minimal brain dysfunction syndrome' refers to children of near average, average, or above average general intelligence with certain learning or behavioral disabilities ranging from mild to severe which are associated with definitions of function of the central nervous system. These deviations may manifest themselves by various combinations of impairment in perception, conceptualization, language, memory and control of attention, impulse or motor function. Similar symptoms may or may not complicate the problems of children

1 with cerebral palsy, epilepsy, mental retardation, blindness,
2 or deafness. These aberrations may arise from genetic varia-
3 tions, biochemical irregularities, perinatal brain insults, or
4 other illnesses or injuries sustained during the years which
5 are critical for the development and maturation of the central
6 nervous system or from unknown causes."

7 The definition also allows for the possibility that
8 early sensory deprivation could result in central nervous
9 system alternations which may be permanent.

10 I have felt for some time that this is a good working
11 definition.

12 DR. KIRK: How does that help me in working with kids

13 DR. BLAIR: Sam, I don't know it does.

14 DR. KIRK: This is a good medical approach, but it
15 doesn't help us. And what I was going to say is we can try to
16 go through a delineation of the characteristics of these kids
17 and we are going to get into trouble just like that. Because
18 to me this doesn't help me a single bit, this definition, as
19 a practitioner.

20 DR. BLAIR: Well, it seems to me --

21 DR. KIRK: I have been trying to think if we can
22 switch gears a little bit and talk about the remedial end.

23 I wish I had this formulated, because this would be
24 a different approach than the medical model.

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25 The medical model is to describe the characteristics

1 of the kids. In education we describe the methodology of
2 behavior change.
3 DR. BLAIR: But I don't think when we define deafness
4 or retardation we at that point are trying to spell out remedi-
5 ation, Sam.
6 It seems to me at this point we are trying to pin-
7 point a condition that exists.
8 DR. DENO: That has been what our problem is.
9 DR. KIRK: That's our problem.
10 MISS TAYLOR: That's what we are fighting.
11 DR. KIRK: I'd like to use the term some way or other
12 in the definition of "remediable deficits." There are some
13 deficits that are irremediable that we know of at this point.
14 Remediable deficits. If we can gear our definition
15 to what we can do for these kids, it would be more educational
16 than the medical model definition which was just read, which to
17 me is of no use. It doesn't tell me how to diagnose a kid.
18 It doesn't tell me how to remediate him. It just gives me a
19 lot of words.
20 DR. BLAIR: I don't think the definition of deafness
21 does either.
22 DR. DENO: We are not making any claims for the
23 definition of deafness. We think it's lousy too. What we as
24 educators are trying to do is state in some way which puts
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25 us in an appropriate dialogue with everyone the fact that our

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1 central concern is with the development of competence in chil-
2 dren. And the medical models are sort of oriented to the cure
3 of disease. Okay. If it could be cured medically, the doctor
4 should have done that.

5 DR. BLAIR: I suspect if I had eliminated the phrase
6 "minimal brain dysfunction syndrome" and had inserted "learning
7 disorders" that this would not appear to be the medical model
8 at all.

9 DR. DENO: Or if you had left in the word "presumed,"
10 because I can --

11 DR. KIRK: Let me say this which every educator knows.
12 You're talking about deafness definitions. Every educator
13 of the deaf knows that decibel loss doesn't define deafness
14 from an educational point of view.

15 You correct me, Mike.

16 We define them in terms of their language development.
17 If they lose their hearing at the age of 12, they are going to
18 be educated differently than the one who lost it at the age of
19 one. So when it comes to the teaching point, the decibel
20 loss isn't the important thing.

21 If a doctor says he is deaf because he has an 80
22 decibel loss, I would say that doesn't help me. What would
23 help me is his status of language.

24 Isn't that right? The language definition is the
25 educational definition really.

1 DR. DENO: Or residual hearing is functional for
2 learning language in the way most kids learn it.
3 DR. BLAIR: I agree, but I think when we say, "Here
4 is a deaf child," we communicate something. And we are not at
5 that point.
6 DR. DENO: That's a fallacy.
7 DR. KIRK: For educational purposes.
8 DR. BLAIR: It seems to me at this point we are not
9 trying to write the book on what you do with the kid. At this
10 point we are trying to define the existence of this condition
11 and not for all time answer every remediation problem.
12 DR. HEWETT: I think Sam's point is so well taken
13 in that he is really confronting us with this most critical
14 problem, as I see it, which is this sort of translatability
15 gap that has existed for too long between what we have said
16 about kids in the world of words and what we have been able
17 to do with them in the world of educational deeds.
18 And it is this translation that is missing from this.
19 And it may be beyond the scope of a meeting like this or a
20 problem like we are trying to solve, but this is the thing --
21 the translation.
22 DR. MYKLEBUST: I think the definition could cer-
23 tainly include what you expected. As a matter of fact, I think
24 committee definitions -- good ones -- do. In the definition
25 that I suggested to you in the material, I stated specifically

1 that in the case of the learning disability child you assume
2 normal outcome.
3 Now, in this regard he is quite different from most
4 any other handicapped child, by the way.
5 But in this child, rightly remediated, you do assume
6 he is going to have essentially normal outcome, and this is one
7 of the ways, of course, in which you can characterize this
8 group of children. Because most of them do not remain depend-
9 ent. Most of them do not continue to be handicapped -- not
10 under proper programs anyway.
11 So, yes, I think that's right. I think that several
12 things have been said here. Extent of involvement in db. And
13 Sam gave us the example of age of onset. Age of onset is
14 obviously involved in every handicapping condition, and it is
15 involved here. We are going to get them at all ages, so age
16 of onset is a variable.
17 So is the extent of the involvement, which is true
18 of every handicapping condition. How much is there? And so
19 this is measuring the deficit, and so on. How much involvement
20 is there is pretty important.
21 But, irrespective of this, I think that it is most
22 logical that we do assume that we are going to have good
23 remedial results in this group. I think this could easily
24 be stated and of course written in.
25 I suppose I feel that such a statement doesn't identi-

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1 that very well. You can say this about various children,
2 various conditions.
3 It would seem to me that in terms of an identifica-
4 tion you can't avoid that you have to spell out something if it
5 is not going to be just the same thing as what we already have
6 in the area, as we said this morning.
7 I think you have to spell out how this child differs
8 from the others. Otherwise I just don't think we have an area.
9 DR. HEWETT: We're talking about children for whom
10 normalcy would be possible in learning?
11 DR. MYKLEBUST: Yes.
12 DR. HEWETT: If there is no question about this, then
13 that's kind of one of the basic assumptions.
14 DR. MYKLEBUST: That is another assumption, Frank,
15 that I make.
16 DR. HEWETT: I wasn't aware of this.
17 DR. MYKLEBUST: Yes, I really do.
18 DR. BLAIR: It's possible but not always predictable.
19 DR. MYKLEBUST: Of course not always, the outcome.
20 But that's impossible in any human being to predict.
21 But the assumption for this population is normal
22 outcome, which is not true of the deaf or the blind or the
23 retarded. To some extent it certainly is true of the
24 emotionally disturbed.

25 DR. HEWETT: I would think it would be more true of

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them.

DR. MYKLEBUST: I would too, Frank.

DR. HEWETT: Than this particular --

DR. MYKLEBUST: I also make the assumption, if we could just take a moment more on this, that in the emotionally disturbed, in the real long-time pull -- maybe not when you are starting with a child that is seriously involved -- the psychology of learning is not greatly modified. In other words, if you can break through the emotional condition, he learns essentially like other children learn.

Now, I don't make that assumption here. I think these youngsters who are unable to integrate auditorially, perceive auditorially, visually, et cetera, which I won't try to spell out here anymore now-- There is considerable evidence, and I really mean even lower animal evidence, that might be very important in the basic science, that these youngsters do not learn in the usual way. So they differ from the emotionally disturbed there I think.

(Reporter's note: Point No. 7 on the board is "Remediable Deficits," and Point No. 8 is "Do not learn in the usual way.")

DR. MYKLEBUST (Continuing): There is another way in which they differ from the emotionally disturbed. Remember now I am just talking about the way I see it.

That is, to some extent yet -- I think less than 15

1 or 20 years ago -- you still make the assumption that you
2 should be very permissive in the environmental manipulation
3 with the emotionally disturbed. Now, you don't have to make
4 that assumption here. As a matter of fact, to some extent
5 you make the opposite assumption -- that you structure and keep
6 certain guidelines pretty definite around this population.

7 DR. HEWETT: This population?

8 DR. MYKLEBUST: Yes. So again I think there is a
9 real difference in approach. So I wouldn't think the same
10 approach for these populations would be indicated is what I am
11 saying.

12 DR. HEWETT: You think that this is passing -- that
13 permissive approach? I don't think that exists anymore.

14 DR. MYKLEBUST: It certainly has gone a long ways
15 out. That's right. I agree.

16 DR. HEWETT: I think that is historically true.

17 DR. MYKLEBUST: I said yes, 15 or 20 years ago it's
18 what we did, isn't it? But certainly today you get them on
19 their feet and ask them to do something.

20 Bob?

21 DR. RIDGWAY: The discussion we have been having
22 here about the type of definition we use, the model we use,
23 is precisely the reason I asked the question of Corrine that
24 I did when we started. Because if this is to be a definition
25 that is going to be useful to people, then it seems to me that

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1 we can do better by talking about processes than by talking
2 about causes.
3 DR. MYKLEBUST: Yes.
4 DR. RIDGWAY: The matter of deficits or the matter of
5 processes rather than a presumed or demonstrable dysfunction of
6 the central nervous system. This I think leaves us really way
7 out in the cold saying it can either be this or not.
8 DR. MYKLEBUST: Yes, I think --
9 DR. RIDGWAY: I would rather talk about things that
10 we can demonstrate, and we can demonstrate deficits in processes.
11 DR. MYKLEBUST: I think the point is well taken. We
12 can easily make this adjustment.
13 DR. RIDGWAY: I really appreciated Sam's comment here
14 about making this definition one that will be useful to teachers
15 who are thinking about going into the field, useful to univer-
16 sity staffs that are thinking about starting programs, useful
17 to public school systems.
18 DR. MYKLEBUST: That is the intention.
19 DR. RIDGWAY: Useful to everybody.
20 DR. MYKLEBUST: That is exactly the idea.
21 DR. KIRK: I think that's the purpose.
22 DR. MYKLEBUST: Corrine, do you want to comment now,
23 please?
24 DR. KASS: Yes. I would agree that we ought to leave

25 out all of the possible neurological terms, such as "central

nervous system," and perhaps even "central processes," because when we do this we are in effect saying it does belong under other health impaired because we are tying it right back again to some part of the body, to some of the physical aspects.

I have just been taking down some of the terms and words which I think reflect purely educational terms and which to my mind would justify making this another part of the listing -- learning disabilities.

And these are some of the assumptions that were mentioned. And the remediation idea. Possible normal outcome from the training. Disorientation in educational environments Learning deficits.

And just very roughly I would say children with learning disabilities might be those with deficits in learning which require special techniques and methods. These deficits manifest themselves in difficulties in learning developmental and academic tasks. Taking it down to the pre-school level, learning walking, talking, speaking, and the academic tasks of school.

These children are not retarded, emotionally disturbed. I think we have to keep this in. We have to say these are not --

DR. MYKLEBUST: And have opportunity for learning.

DR. KASS: Yes.

DR. KIRK: Let me draw something on the board.

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1 DR. MYKLEBUST: Sure. Go ahead.

2 DR. KIRK: To clarify what you are doing here.

3 (At the blackboard) We are saying in the field of

4 education of the handicapped we have different groups. This

5 group is mentally retarded. We have a program for them.

6 Whether it's good or bad, you know, this is defined. The Gov-

7 ernment gives money for training teachers. Whether they train

8 them right or not, at least they do it on a practical basis.

9 They give research.

10 We have another group called blind or visually handi-

11 capped.

12 We have another group called deaf.

13 We have another group called emotionally disturbed,

14 whatever that means. Can you define that for us, Frank?

15 DR. HEWETT: I wouldn't try. (Laughter)

16 DR. KIRK: Now, what we are saying is that we have

17 a kid here that-- I don't want to list all the kinds here.

18 It's just an example. We say that this kid is not deaf. If

19 he were, we'd put him in this program (indicating).

20 What did I say this was (indicating)?

21 DR. MYKLEBUST: Blind.

22 DR. KIRK: He's not blind. Otherwise we'd put him

23 here.

24 If a kid came to me, I'd try to find out.

25 He's not mentally retarded. Otherwise I'd put him

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1 here.

2 And he's not emotionally disturbed in the ordinary
3 sense.

4 But the kid isn't getting along. He isn't developing
5 properly, pre-school level. He has developmental deficits in
6 some areas, talking, walking, speaking, understanding particu-
7 larly in the communication process.

8 And so this group is in the middle. But he is not
9 exclusive. So what we have is a group that overlaps some of
10 these.

11 Now, for some of these kids -- emotionally disturbed
12 -- I may set up the treatment as learning disabilities. I
13 think I can get farther with this kid by training him as I
14 mentioned to you.

15 Here is a kid that goes to second grade, and then he
16 comes home, and next morning he vomits and he is sick and he
17 can't go to school. And he can't go to school and can't go to
18 school. The pediatrician says there is nothing wrong with
19 his stomach. Nothing there. He can't find anything wrong.

20 Finally they say this kid is emotionally disturbed.
21 "Send him to a psychiatrist."

22 Then we test him and find out the kid has an IQ of
23 140 but hasn't learned a single word in reading.

24 You make an analysis of him. You find a couple of
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25 what I call psychological deficits, whether they are central

1 nervous system involvement or not. After all, everything comes
2 from the brain, so you can make that statement. I don't have
3 any objection to it particularly. It's that we haven't brains
4 enough to find out whether it is biochemical, genetic. We
5 can't tell in these kids. So, whatever they say it is doesn't
6 help me. I can just forget about it, because it isn't doing
7 me any good.

8 So what I want to find out is what he can do, you
9 know. Is there something here that is inhibiting his ability
10 to read? Then I'll work on this.

11 So I will say I have found two remedial deficits, and
12 I'm going to set up the remedial program.

13 Is he emotionally disturbed? For that kid I treat
14 him as learning disabilities. After you teach him to read,
15 he stops vomiting and goes to school and is a little more
16 motivated.

17 But the point is, as Mike said, let's not spend all
18 our time on this group, the overlapping group, at this time.
19 Let's first try to define this central core group in a sense
20 that isn't overlapping. I mean if we did that first, then I
21 think after we do that we will say, "Of course, this group
22 overlaps with these, and we can't define it because it's
23 up to a professional diagnostician to determine."

24 I have got some cases here where they have been

25 diagnosed as mentally retarded. But I treat them as learning

1 disabilities. I am finding they are remedial deficits that
2 will make them approach normal. And we make them relatively
3 normal even though somebody has classified them here, even
4 though a professional diagnostician has classified them here.
5 The remedial method is different for this kid than
6 for this kid (indicating), you see, even though both of them,
7 say, may have an IQ of 65 or 70.
8 So I think what Mike says may lead us a little
9 further. Can we do this without any problem?
10 Here's a deaf kid that learned speechreading. Here's
11 another deaf kid that can't. This kid probably has a deficit
12 in the visual representational process of some kind where he
13 can't learn speechreading. There is something perceptually
14 wrong with him. We don't know it. So you can fool around
15 with these and do something here. We know that.
16 But I think we will save time if we define this
17 group first (indicating). I like to define it in terms of
18 not the medical model, Frank, because I think this is the
19 thing that has caused us a great deal of difficulty, because
20 it doesn't help me as a remedial teacher. It has no bearing
21 on what I want to do.
22 DR. BLAIR: I'm not convinced this is a medical
23 model as much as --
24 DR. KIRK: Who was that committee?

25 DR. BLAIR: I understand --

1 DR. KIRK: They are all MD's except Myklebust. He
2 didn't attend half the meetings. What are you going to do
3 when you have 15 MD's around? What can the medical group do
4 but set up a medical model? Do you think they're educators?
5 DR. BLAIR: From an extension of their work which is
6 here, hard work on identifying symptomatology of the children,
7 this goes way beyond the medical as far as I'm concerned.
8 DR. KIRK: I object to that, because they didn't
9 really define symptomatology in such a way I can deal with it
10 educationally. Just intellectually.
11 DR. BLAIR: The point you are addressing yourself
12 to, Sam, in terms of identifying this middle area is-- At this
13 point I think we can't be this specific about what you do for
14 the children. I think this is still an area for research and
15 so on. We still don't know all the answers to remediation.
16 We know many answers.
17 DR. KIRK: Can we make the statement they have
18 remedial psychological deficits?
19 DR. MYKLEBUST: You wouldn't object?
20 DR. BLAIR: No, I wouldn't.
21 DR. KIRK: That properly handled would make the kid
22 approach normal.
23 DR. BLAIR: What I'm concerned about is whether we
24 are getting too broad in our scope, whether we are going to
25 cloud the issue and whether we are going to really depart from

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1 a rather succinct kind of definition. It seems to me this is
2 what we are trying to do.
3 DR. KIRK: I'm trying to follow Myklebust's lead.
4 Let's not spend our time on these (indicating) --
5 DR. BLAIR: I agree.
6 DR. KIRK: -- and let's get a hard core. And I'm
7 adding let's not spend our time trying to find out what is a
8 central nervous system defect. A lot of us know a lot of these
9 kinds of some kind of dysfunction of brain. Exclude those and
10 we might get farther.
11 And then, if we do this, I think we can qualify this
12 statement with this, this, and this.
13 DR. BLAIR: I'm wondering what the elimination of
14 central nervous system dysfunction does to our definition. I'm
15 concerned about this.
16 DR. MYKLEBUST: Let's look at that, Frank. It might
17 not do as much damage to it as it seems. Because you can
18 define this educationally without reference to etiology, can't
19 you? And it is entirely possible that that is the most logi-
20 cal and useful thing to do at this time.
21 Corrine's beginning statement here takes us into
22 that possibility, doesn't it?
23 So I would suggest that we might try to see what
24 we have here by elimination if we are ready for it. I think
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25 Bob's comment is extremely well taken too. And thank you, Sam,

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1 for this clarification again.

2 I think that we might begin to-- Maybe we shouldn't.

3 Maybe it's premature. But if we did start without any implica-

4 tion for this and see how it comes out, I would be happy to

5 see what we can do with it and describe this child as an entity

6 who isn't blind, doesn't have visual impairment, deafness, and

7 so on, and then I think the crux of what Frank is concerned

8 about will be then where we come up with what he is.

9 As I indicated this morning, if you just define him

10 as what he isn't, you are just talking about a normal child.

11 So then we have to get into what he is, which does force us

12 to say something about what his deficits are.

13 DR. KIRK: Right.

14 DR. MYKLEBUST: And then something about the nature

15 and extent and also some of the prognosis or the outlook,

16 which we are indicating here is very favorable if the young-

17 sters are properly managed.

18 Shall we try that for a time? We still about half

19 an hour before coffee break. Do you want to try that for a

20 while?

21 Does everyone feel we are ready to see if we can do

22 this now -- eliminating some of these things that have been

23 confusing in the past?

24 I want you to know I am compromising. (Laughter)

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25 I'll give up the ghost pretty soon. (Laughter)

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1 I'm all for the compromise. Bill?

2 DR. WOLFE: I'd like to ask a question. Again, this

3 is so very basic.

4 DR. MYKLEBUST: Go ahead.

5 DR. WOLFE: I'm asking it somewhat apologetically.

6 Are you suggesting that a "gifted child" if he's not achieving

7 at his intellectual level would have then the wherewithal for

8 this label "learning disability"?

9 DR. MYKLEBUST: Well, properly measured, I would have

10 to say yes to that when you leave out etiology. Properly

11 measured.

12 Because, as you know, I feel keenly that this deficit

13 measurement has to be done in a certain way.

14 DR. WOLFE: I got the idea from reading this material

15 DR. MYKLEBUST: Yes, if he is gifted and then accord-

16 ing to whatever it is you are asking him to learn is not being

17 actualized by certain criteria, then I think he has to be

18 considered a child with a learning disability according to

19 what we are saying.

20 DR. WOLFE: Fine. Let me go ahead.

21 DR. MYKLEBUST: May I add that is the way I under-

22 stand our discussion right now.

23 Go ahead.

24 DR. WOLFE: Then are we not over-emphasizing? Be-

25 cause it is my strong belief that 90 per cent of the public

1 school programs in this country are not geared to take care
2 of the gifted child.
3 DR. MYKLEBUST: Yes. I would think though he --
4 DR. WOLFE: Therefore, aren't we getting a false
5 measure here then of this particular child when he is not
6 properly challenged, when our public schools are not properly
7 geared to take care of him?
8 DR. MYKLEBUST: I think we all appreciate very much
9 Bill's question, because, you see, we are faced with now de-
10 fining an under-achiever versus a youngster with a learning
11 disability.
12 DR. KIRK: That's the question.
13 DR. MYKLEBUST: And, of course, you will be right
14 into including everybody if we don't watch this.
15 DR. WOLFE: Particularly in the gifted bit, because
16 our schools are not doing the job.
17 DR. MYKLEBUST: We are certainly going to have to
18 do something with it.
19 DR. KIRK: He is not a learning disability, you see.
20 DR. MYKLEBUST: Under-achiever.
21 DR. WOLFE: He is by Mike's definition first, but
22 he isn't when you look at the reality. Right?
23 DR. KIRK: Bill, I don't know who commented on
24 education in general.

25 DR. WOLFE: I did.

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1 DR. KIRK: We cannot --

2 DR. MYKLEBUST: Bill did.

3 DR. KIRK: We cannot take in the whole educational

4 field.

5 DR. WOLFE: I realize this. But I think we had bet-

6 ter state something here for those people to read, you see, so

7 that we will not pose more problems for them.

8 DR. MYKLEBUST: But now Bill is concerned about what

9 criteria we are going to use to say he is deficit in learning

10 as a result of a learning disability and not deficit as an

11 under-achiever because he isn't being assimilated properly.

12 And I think we have to consider that.

13 DR. RIDGWAY: What about No. 5?

14 DR. MYKLEBUST: And Bob comes up and says, "What

15 about No. 5?" Well, Bob, if we leave something like No. 5 in,

16 as I see it, we begin to protect ourselves. Now, you have to

17 have evidence that he isn't normal and simply not being assim-

18 ilated, I would think.

19 Any other comments on that?

20 Lou?

21 DR. FLIEGLER: It wasn't a comment. I don't know

22 how you knew I wanted to say something.

23 DR. SELZNICK: It was in your eye. (Laughter)

24 DR. FLIEGLER: I'd like to ask a naive question

25 first of those of you who have stated rather positively that

1 you know who these kids are. What are one or two criteria
2 clinically that would characterize this youngster as a learning
3 disability?
4 DR. KIRK: Are you talking about-- Let's take the
5 most common kind of child who goes into the first grade and
6 second grade and third grade and he isn't learning to read,
7 let's say. Right? Clinically we give him an intelligence test
8 to see if he is normal or potentially normal intelligence.
9 That's step No. 1.
10 The next step is we would give him a reading test,
11 and we find he is at the bottom of the first grade and he is
12 now eight or nine years old. Now we say there is a discrepancy
13 between his mental development and his educational development.
14 Now, then, the third step is I want to find the corre-
15 lates, and I don't mean physiological correlates necessarily.
16 I mean psychological correlates. All clinicians are trying
17 to find out what psychological deficits this kid has that
18 have tended to inhibit his ability to learn under ordinary
19 instruction. I am assuming ordinary instruction.
20 Now, I may give him a lot of tests or Mike may give
21 him a lot of tests, and I will use his terminology. He talks
22 about auditorization and visualization. Now, we have tests for
23 these. And if we find the kid is very deficient in visualiza-
24 tion ability, inability to reproduce visual symbols in sequence,
25 if he is unable to auditorize, discriminate auditorially, even

though he can hear, or blend sounds, then I say he has got two disabilities.

Now, then, that tells me that in the remedial program for this kid I had better correct these psychological deficits, and I will attach it to a reading program.

I will teach him to soundblend and teach him to reproduce the Fernald, the phonics system, as an auditorization system.

So I may use these at different stages, but it defines for me the remedial process, hoping with this process I correct his psychological deficits and teach him to read.

Now, that is simple, but I have to look at the correlated psychological deficits, so I tend to define a learning disability as that which has demonstrable psychological symptomatic-- Not brain. Even though I concede it may be there, I can't test it. But I can test his psychological deficits and auditorization and visualization and other things, you see.

Now, if I can demonstrate that this kid has these psychological deficits as correlates, discrepancy between mental chronological development and the other, then I will classify him as a learning disability.

On the other hand, he may be eight or nine years old and I test his mental development and find he is normal. I test his educational development and it is only first-grade.

1 I try to find some correlated psychological deficit,
2 and I can't find them. He just hasn't been in school. And
3 that's the educationally retarded child Bill Wolfe is talking
4 about, and I would not classify him as a learning disability
5 unless I can find basic psychological-- This is analyzing the
6 symptoms of behavior.
7 DR. WOLFE: We had better make this clear though.
8 DR. MYKLEBUST: That's right.
9 DR. WOLFE: May I react to Lou's question?
10 DR. KIRK: Excuse the speech.
11 DR. FLIEGLER: Quite all right. You cleared it up.
12 DR. MYKLEBUST: Are you through, Lou?
13 DR. FLIEGLER: Yes.
14 DR. MYKLEBUST: Bill?
15 DR. WOLFE: Let me try to rephrase what Sam has said
16 in just a short sentence possibly. Could we not use the two
17 terms "globally involved" and "scatter performance" on the
18 results of individual psychological tests? Would this not
19 be a clue? That is what I am asking.
20 A person who is globally involved is not the guy
21 we are talking about -- if he is low, that is. The guy though
22 that is scattering in his performance certainly would be a clue,
23 though, would it not?
24 DR. MYKLEBUST: It would be a clue, yes.
25 DR. WOLFE: A clue only, yes. Isn't this what we are

talking about, Sam, when you ask for something the clinician or the teacher could use in helping her identify this problem?

dr. myklebust; By psychological tests now you mean mental tests?

DR. WOLFE: Mental tests, individual tests.

DR. KIRK: I'm talking about analytical tests.

DR. MYKLEBUST: We would include the whole battery.

DR. WOLFE: I know. But I'm speaking of the individual psychological examinations.

DR. KIRK: It doesn't help me in remediation. It tells me what his level of reading is. But it doesn't help me in remediation. But what I want to do is find out what is wrong with this kid. Why has he been in school three years and hasn't learned? Then I go through correlates.

Maybe he has got a fusion problem. Maybe he has got auditorization problems or visualization problems. Maybe he has some other disability. I want to find it.

If I can't find these-- I mean it's up to the diagnostician to prove that there is something wrong in the developmental process and it is developmental discrepancy. And at the preschool level you cannot tell it. At the school level you can tell it.

DR. BLAIR: Sam, I think if there is any agreement we have I think it is on this point.

DR. KIRK: All of us do the same thing in the

1 symptomatic. We get bogged down when we talk about the hypo-
2 thalmus and the adrenal cortex.
3 DR. MYKLEBUST: Now, if I may, there are some who
4 haven't had a chance to get in on this. Sam, you're one. Go
5 ahead, Sam.
6 DR. ASHCROFT: I just wanted to ask if the kind of
7 problems you have just enumerated in visualization, auditoriz-
8 ation, could be subsumed under "cognitive function."
9 Let me tell you where I am going if your answer is
10 yes.
11 DR. KIRK: You will have to define "cognitive" for
12 me, because "cognitive" in my terminology is more at the mean-
13 ing, representational level, and these others are more basic
14 and non-meaningful. The kid has them or doesn't have them.
15 You can take a kid, you know, and he can't close.
16 He can't put parts together in a hole. So kids have it or don
17 have it, and they develop that way. And this reading is a
18 closure process primarily.
19 So what do you mean by "cognitive"? Then I will
20 answer your question.
21 DR. MYKLEBUST: Do you want to go ahead, Sam?
22 DR. ASHCROFT: Yes. I mean learning.
23 DR. MYKLEBUST: Why don't you tell us what you had
24 in mind?
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25 DR. ASHCROFT: Well, it is the same model, the

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1 discrepancy model, in terms of expectation versus achievement
2 and then discrepancy. And then we in another sense develop
3 hypotheses about the source of the discrepancy. And we rule
4 out for these children instructional things, environmental
5 social factors, emotional factors, sensory factors, and physi-
6 cal factors.

7 And I would like it if we could wrap it up in some-
8 thing like cognitive functions. But that apparently isn't
9 quite --

10 DR. MYKLEBUST: I agree with Sam. There's lots of
11 trouble with the term today.

12 Anything else, Sam?

13 DR. ASHCROFT: No.

14 DR. MYKLEBUST: Bill Heller, what do you have to say
15 before coffee break?

16 DR. HELLER: Sam and I were drawing the same pic-
17 tures. And I am interested too in defining that core first.
18 In fact, I have the same thing here that he drew.

19 Also I think on that second point up there the thing
20 that bothers me here that we haven't brought in is the situ-
21 ation which goes to the educational situation that we are
22 talking about. It's something Evelyn mentioned too.

23 We are defining this in terms of where we are seeing
24 the child, and he is functioning in an educational situation.

25 DR. MYKLEBUST: I don't quite get your point. Is

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1 this good or bad?

2 DR. HELLER: Well, we are talking about deficits and

3 bringing in in the preamble here that we are talking about edu-

4 cation. It could be a part of this -- learning and/or be-

5 havioral deficits occurring where?

6 DR. MYKLEBUST: I see. Well, all right.

7 Now, let's see. Evelyn, did you get through? Do you

8 have anything else right now?

9 DR. DENO: No. I'm still with the point that you

10 are defining dysfunction in terms of adequate -- having had

11 adequate opportunity to learn.

12 DR. MYKLEBUST: You don't think you could make such

13 an assumption?

14 DR. DENO: No, I think that's all right.

15 DR. MYKLEBUST: Phil?

16 DR. DENO: But that it should be in here. The child

17 has had adequate opportunity to learn.

18 DR. MYKLEBUST: Absolutely. It has got to be.

19 DR. DENO: This isn't necessarily just in school.

20 DR. MYKLEBUST: If you don't, you have the whole

21 cultural deprivation for which there are entirely different

22 laws and regulations and funds and everything.

23 Yes, Bill?

24 DR. HELLER: On No. 7 I would just put in "potentia-

25 ly remedial," because from a teaching standpoint --

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1 DR. MYKLEBUST: Yes.

2 DR. HELLER: -- if someone gave me a report and said
3 that this is remediable and I didn't remediate it, there may
4 be something outside my teaching ability.

5 DR. MYKLEBUST: Exactly.

6 Phil?

7 DR. HATLEN: Not much right now. I have been draw-
8 ing diagrams too. And I started out with all children and
9 ended up with a little narrow group in the middle which over-
10 laps in both directions. And it seems to me in very general
11 terms these are simply the kids that don't have any handicap
12 as is now defined but don't operate in regular classrooms, and
13 I don't know that any of this has helped me any further as
14 far as what I am going to do with the child in the classroom.

15 DR. MYKLEBUST: No, it really isn't intended to. I
16 must stress that the whole process of remediation would be som
17 thing else.

18 I would think that we can imply remediation here all
19 the way, and so on, but it would seem to me that we are trying
20 to agree on how to identify the child, who this youngster is.

21 I do think that, should we get too far into the
22 remediational aspects, again it would be quite an impasse.
23 I really think so.

24 There are things you can do today it is quite
25 obvious. In this State you certify teachers for learning

1 disabilities. We have been doing it for four or five years.
2 And some other States, of course, are very much along the
3 lines of the same procedure.

4 This assumes that you train these people in certain
5 ways just like it does in the other areas of handicapped chil-
6 dren.

7 I think then could I try to-- I'm not trying to
8 terminate anything, but maybe we are ready for a coffee break.
9 It seems to me that as a group we are saying that we want a
10 description, operational definition, that says something about
11 this child's integrities, what he can do, what he is. That is
12 he is adequate intellectually.

13 And, of course, as you know, some of us have worried
14 a great deal about what we mean by "adequate intellectually."
15 He is adequate in his sensory functions, his vision, his hear-
16 ing.

17 Again, despite the fact that we have years of ex-
18 perience there, there is still a great deal of disagreement
19 about it. And right now in this State we are in the process
20 of writing a whole revised definition of who the hard of hear-
21 ing child is.

22 We say he is adequate in vision. All of these
23 things make assumptions which I would think we would probably
24 want to try to get at next, as to what do we mean by these,
25 if he isn't this and this, taking the diagram, what Corrine

1 presented, and some of these, and that he is, however, deficit
2 in certain respects.
3 It seems to me that that is perhaps where we are
4 yet not very far along in our discussion. We have certainly
5 been referring to it. We perhaps will have to come back to
6 something of that type.
7 What did you have on deficits, Corrine?
8 DR. KASS: Oh, not much, because what I wanted to
9 point up was the fact of deficits which require special tech-
10 niques and methods.
11 DR. MYKLEBUST: Yes.
12 DR. KASS: In other words, the requirement of some-
13 thing other than going back and correcting or filling in would
14 be the key.
15 DR. MYKLEBUST: This might be a good key here to
16 alleviate the need to approach the deficit problem in various
17 details and technical ways, but this then remains to be seen.
18 Sam?
19 DR. ASHCROFT: Is there a useful distinction that
20 might be made between discrepancy and deficit? What I am
21 thinking of is, "deficit" implies a lack and to me is less
22 remediable than "discrepancy."
23 And we really take expectation in terms of the child
24 and then look at some discrepancy between what we could
25 anticipate and what he is producing.

DR. MYKLEBUST: Yes. Well, I think the point is well taken that these terms certainly should be looked at both ways.

I take just a moment to tell you that we did work on the learning quotient now for almost two years. You can measure under-achievement versus potential with considerable scientific accuracy. I would plead that cause. I think we have done it. You can do it. You can show that it is quite meaningful to schools in terms of expectancy age, what he is supposed to be learning and what he is learning as a ratio.

You can quite accurately show that this child has, therefore, a discrepancy -- we have been calling it "deficit" -- a discrepancy between potential for learning and actual learning.

At this point all you have done is to describe under-achievement.

DR. KIRK: Right.

DR. MYKLEBUST: And then from this point on you have to decide by some criterion. It might be by the elimination of what we have said so far today, because that is the only way to avoid it except through etiological terminology it seems to me.

But then if you say that he is not otherwise retarded, sensorially impaired, emotionally disturbed, and so on, then something about processes like Corrine has here may pick

it up. Then this would eliminate the regular under-achiever.

Bob, you have something?

DR. BLAIR: I have something started. Do you want to hear it now or after coffee?

DR. MYKLEBUST: Bob is first. Go ahead.

DR. RIDGWAY: Mine was shorter. It seems to me including the things you were talking about and the things we seem to have general agreement on, something like this might come out: That such a child, a child with learning disabilities, has a remedial deficit in one or more of the psychological processes of perception, association, and expression which require educational programming different from that in the typical classroom. These deficits are not primarily sensory, caused by generalized retardation or emotional disturbance.

This in essence is what you were saying.

DR. KIRK: Are not the result of.

DR. RIDGWAY: Yes.

DR. MYKLEBUST: All right. Fine, Bob.

Frank?

DR. BLAIR: Well, it is similar I guess. I haven't quite finished yet. But the term "learning disabilities" refers to children of average or above intellectual potential having adequate environmental and/or educational opportunity who, for reasons not primarily related to sensory disorders, generalized mental retardation, or emotional disturbance,

1 manifest disruptions in essential processes of verbal and/or
2 nonverbal learning.
3 Such children generally demonstrate a significant dis-
4 crepancy between expected and actual learning achievement.
5 The conditions manifest in these children may involve
6 impaired perception-- And then I was going to go on and list a
7 few.
8 DR. MYKLEBUST: Well, I think this is a good time for
9 a little break. It has been a good hour.
10 (Whereupon, a recess was taken.)
11 DR. MYKLEBUST: Now we are ready to go again.
12 A couple of people were cut off a little bit there by
13 the coffee break. Both Corrine and Jim Chalfant. Corrine, do
14 you want to take it first?
15 DR. KASS: No.
16 DR. CHALFANT: I really don't have anything to say no
17 DR. MYKLEBUST: You have settled down already?
18 (Laughter)
19 May I ask you now as a group: Do you want to take
20 whatever time it takes, the next hour or whatever, to get fur-
21 ther into the question of extent of involvement, how much dis-
22 crepancy between potential and learning?
23 Well, I don't know just where it comes in mostly on
24 our outline up here, but it seems to me that it is possible we

25 have fair agreement on some description that these children ar

1 not so and so, and so on, despite the fact they have good oppor-
2 tunities for learning.
3 Now, getting to the question of involvement, you know
4 in the past years a child has been considered retarded in his
5 educational achievement if he were one, two, three or more
6 grades below where he was expected to be. In our own efforts
7 we have this much too loose a definition, so we have proceeded
8 to evolve a way in which to appraise this in other terms.
9 Now, how you appraise the extent of it and what cut-
10 off you take, of course, will give you something as to inci-
11 dence problems -- how many of these children, how many of what
12 type, and so on.
13 How do you feel about it? Would you like to take
14 that for a little while?
15 Bob, did you have a comment on this?
16 Or do you want to go back to where we were on more
17 of the concept and problem that we are talking about?
18 DR. FLIEGLER: I would like to firm that up, Mike.
19 I think we have reached a critical stage, and I think we have
20 heard two fine definitions. We may want to change the order
21 a little bit. But there is no doubt -- and I think Sam res-
22 ponded quite accurately -- that certainly Nos. 1, 4, 5, 6 with
23 some change in wording, and 7 are included pretty much, with
24 the crux of the matter being 5. I think this is essential.

25 There is no area in special education except for

1 perhaps one where we have hung our hat on this.

2 I think if we could firm up the basic elements, since

3 we have them here, that we would be on the road to success.

4 And we all recognize that certainly we are rushing, but I think

5 we have thought a lot about these things. We have all come

6 here fairly well prepared.

7 And then, if you don't mind, I think it would be im-

8 portant to move to that discrepancy quotient. Because if you

9 remember this morning we pointed out that much of definition,

10 regardless of the incidence, is based upon some statistical

11 referent, whether we like it or not, and since we are develop-

12 ing this definition for legislators and so on.

13 And then, hopefully, we would come back -- and we

14 have two definitions which are really very much related --

15 and see if we can firm it up.

16 DR. MYKLEBUST: Very good, Lou. Do you suggest we

17 take these one at a time? I see No. 1 there as being repeated

18 in No. 4 under retardation. Not primarily sensory. Or if

19 we say not primarily mental retardation, you have really said

20 No. 1, haven't you?

21 Would you agree No. 1 is repeated there in No. 4?

22 They both are referring I think to the level of mental ability.

23 Or you could change No. 4 to say potentially normal

24 intelligence, if you don't want to state it in terms of the

25 negative as not mentally retarded.

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1 And then you said 1, 4, 5, 6 and 7, didn't you, Lou?

2 DR. FLIEGLER: That's right. These seem to be the

3 basic elements.

4 DR. MYKLEBUST: Yes. Then it is possible, Jim, that

5 if you want to take this --

6 DR. KIRK: No. 5, he said.

7 DR. MYKLEBUST: Yes, but No. 4 too, didn't he?

8 1, 4, 5, 6, and 7.

9 All right. Why don't we sort of re-do this? Shall

10 we see where it comes out?

11 Now, please come in here, folks. What would you say?

12 Shall we leave No. 1 out and state it all under No. 4, what

13 is now No. 4? That might become No. 1, you see.

14 Bob, tell us what you would do.

15 DR. RIDGWAY: I would do just as you suggested. Have

16 No. 4 be the primary way to exclude people that are now includ-

17 ed in other programs.

18 DR. MYKLEBUST: Then we can leave out 1, 2, and 3,

19 Jim. Why don't we take them out and start over here and see

20 what we come up with. Okay?

21 DR. KIRK: Children with learning disabilities are

22 those who do not have primary sensory --

23 DR. MYKLEBUST: Good, Sam. Put it right up here,

24 Jim.

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25 DR. KIRK: Something like that. We use the exclusion

first and say what they aren't, and then what they are.

DR. MYKLEBUST: Good. Now, we need everyone's thinking on this in words now. We are going to see if we can make a statement here, Lou, that will include what you have just indicated.

DR. CHALFANT: Children with learning disabilities are -- ?

DR. KIRK: -- are those who do not have primary deficits in sensory, intellectual, or emotional disturbance. Is that stating it? Or is that too much?

MISS TAYLOR: I don't think that is really stating it. I think we should describe the child and then say that these deficits are not primarily due -- are not due to these things. Then we do not eliminate the possibility that a child who happens to have one of those might also, completely separate from the first-- I mean, that is, your fringe group then may also have a learning deficit.

DR. KIRK: You can state it positively or negatively.

DR. FLIEGLER: Let's put the other one up here. Sam, do you mind?

DR. KIRK: No, there's nothing sacrosanct.

MISS TAYLOR: Let's describe these children -- children who have a deficit in one or more, et cetera.

DR. KIRK: I would say "are those who have had adequate instruction and opportunity and in spite of that who"

1 opportunities, show deficits (discrepancies) in developmental
2 and educational (psychological) processes. . .")
3 MISS TAYLOR: Are we going to put disorientation in
4 the educational environment, or is that included in the other?
5 DR. KASS: "Which can be."
6 MISS TAYLOR: Maybe we could put "show potentially
7 remedial" --
8 DR. FLIEGLER: We'll change it later. Okay?
9 DR. MYKLEBUST: Sure. Go ahead and put it up there.
10 DR. FLIEGLER: Don't worry about antecedents and so
11 on.
12 DR. KIRK: Which are, through proper remedial methods,
13 remediable. With special remedial measures.
14 DR. CHALFANT: Responsive to special remedial meas-
15 ures.
16 DR. KIRK: Can be ameliorated, or something like
17 that. Use the term "amelioration."
18 DR. KASS: That's too medical.
19 DR. MYKLEBUST: Say it very simply -- which are re-
20 mediable through special education.
21 DR. RIDGWAY: We stated earlier "remedial deficits
22 in these areas."
23 DR. KASS: "Show remediable deficits." Yes.
24 That would be good.

25 DR. HATLEN: You added "which require special

1 techniques."

2 DR. FLIEGLER: Which are remediable through special

3 techniques? All right?

4 DR. KASS: Which can be alleviated through special

5 techniques.

6 DR. KIRK: You don't want to use the term "amelior-

7 ate"?

8 DR. KASS: No, because we have "remediable" in there.

9 DR. MYKLEBUST: He says "ameliorated."

10 DR. KIRK: You say that's a medical term. I don't

11 think it is.

12 DR. KASS: I mean, you know --

13 MISS TAYLOR: And which are not caused by.

14 DR. KIRK: The result of.

15 MISS TAYLOR: The result of. That's good.

16 DR. KASS: Which are not primarily the result of.

17 MISS TAYLOR: Yes.

18 DR. KIRK: Sensory, motor, or intellectual deficits.

19 DR. FLIEGLER: Central, motor, --

20 MISS TAYLOR: You want "emotional" in there.

21 DR. KIRK: You don't want "central" there. Sensory.

22 DR. FLIEGLER: Sensory? I'm sorry.

23 MISS TAYLOR: "Emotional" you do though.

24 DR. MYKLEBUST: Yes. Sensory, motor, intellectual,

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25 DR. KIRK: Intellectual or emotional disorders or

1 deficits.

2 Frank, what did you have in your definition?

3 DR. BLAIR: I think that's a little awkward. I think

4 it has all the points. I don't think "remediable" belongs at

5 that point. I think it should come in as a final statement

6 perhaps.

7 What was your question, Sam?

8 DR. KIRK: Your definition included a lot of those.

9 I wonder what we missed from your definition. That's all.

10 DR. BLAIR: Not much. I think it's a matter of just

11 language arrangement. I would be happy to repeat it.

12 DR. KIRK: Go ahead.

13 DR. BLAIR: The term "learning disabilities" refers

14 to children of average or above intellectual potential having

15 adequate environmental and/or educational opportunity who,

16 for reasons not primarily related to sensory disorders, gen-

17 eralized mental retardation or emotional disturbance, mani-

18 fest disruptions in essential processes of verbal and/or non-

19 verbal learning.

20 Is that in there?

21 DR. RIDGWAY: Yes, developmental and educational pro-

22 cesses.

23 DR. BLAIR: Such children generally demonstrate a

24 significant discrepancy between expected and actual learning

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25 achievement. The conditions manifest in these children may

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1 involve -- and I have added a few things -- such areas as
2 impaired perception, conceptualization, verbal language develop-
3 ment, reading, writing, numerical concepts, spatial orienta-
4 tion, social perception.
5 Then, to bring in the remedial aspect, I said these
6 disruptions in learning are in most instances remediable when
7 special educational techniques are employed.
8 DR. WOLFE: I like his. I think it's very good, com-
9 prehensive.
10 DR. BLAIR: I think we can certainly question the
11 listing here I have of the kind of deficits. And then your
12 criticism, Mike, of whether mental retardation should be in-
13 cluded too.
14 DR. MYKLEBUST: Whether you need that statement. The
15 first paragraph Frank reads there to me is a little heavy and
16 a little hard to follow.
17 DR. BLAIR: It's long.
18 DR. MYKLEBUST: It's a long one. It sounds like
19 Proust. It's "Prousty." When we studied Proust and compared
20 him with a lot of other people to find out why he was difficult
21 we found out it was because he wrote as much as 60 and 70 words
22 in a sentence.
23 Frank, you're "Prousty." (Laughter)
24 DR. BLAIR: That's the nicest thing that has been
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25 said about me all day. (Laughter)

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1 DR. MYKLEBUST: But I agree, Bill. I think this is
2 real progress.
3 How do you want to proceed now? Do you want to alter
4 what we have, and should we re-do Frank's? Shall we re-do this?
5 Yes, Jim?
6 DR. CHALFANT: If I were a Congressman, I would say,
7 "What do you mean by developmental and educational processes?"
8 DR. MYKLEBUST: Yes.
9 DR. KIRK: I think what we want is a general defini-
10 tion, and then follow what Jim did in one thing here -- turn
11 around and define the words that were used.
12 DR. KASS: By all means.
13 DR. KIRK: In more specific terms.
14 DR. MYKLEBUST: Yes.
15 DR. KIRK: I think if we do that-- You can't put
16 everything in a general statement, but you can put a fairly
17 good general statement that I would agree with.
18 I would take "in spite of" out of there.
19 DR. WOLFE: Put in "yet."
20 DR. KIRK: "Who still could not."
21 DR. WOLFE: "And yet show."
22 DR. KIRK: Yes -- "and yet show."
23 DR. BLAIR: Isn't that all one sentence, speaking of
24 Proust?
25 DR. KIRK: Well, Frank, as I understand it, people

1 like me have to write in short sentences, because they are not
2 smart enough to write 60-word sentences and make sense out of
3 it. Those who can do that really have ability.
4 We did this in a group here, which is phenomenal.
5 It doesn't make sense, but we did it. (Laughter)
6 Remember, now, I think this has to be followed as Jim
7 said-- We have to follow to define our terms here used in this
8 definition.
9 By "remedial deficits" we mean that by special tech-
10 niques and learning situations the children can be improved,
11 ameliorated, approach normal in these deficits.
12 By "educational" we mean disabilities such as in read
13 ing, writing, arithmetic, spelling, and so forth.
14 By "developmental" we mean primarily the communica-
15 tion process, perceptual, and the communication process as
16 such, if you include perceptual in the communication process.
17 Because we are talking there of delayed speech, delayed languag
18 delayed perception, inability to see things right, inability
19 to understand things right, inability to operate primarily
20 communication.
21 DR. MYKLEBUST: But this is a term that today much
22 work is-- It's not negotiable.
23 DR. KIRK: Communication?
24 DR. MYKLEBUST: You can't get together on it at all.
25 "Language" you can get somewhere with. If you mean verbal or-

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1 I think there is something here that is indicated. Either say
2 verbal or nonverbal, or language or non-language, or something
3 like this.
4 Well, I think communication theorists, the psycho-
5 linguistics-- There are hundreds of people who get into com-
6 munication. It is very hard to hold down in any way.
7 DR. KIRK: Let's spell it out by saying in learning
8 to talk, in learning to --
9 DR. MYKLEBUST: You can call it language, you see.
10 DR. KIRK: How about perceptual?
11 DR. MYKLEBUST: Then you have to use that also. You
12 couldn't use just language, no.
13 DR. KIRK: Okay. We can use in psychological, devel-
14 opmental, and in visual, perceptual, in language, verbal, non-
15 verbal, whatever you want. But I think in the definition we
16 ought to spell out a little bit what we are talking about that
17 applies to both pre-school and school.
18 DR. MYKLEBUST: Well, I would agree. I wonder if
19 we could avoid some of these very troublesome terms today.
20 "Perception" is very troublesome to everybody. Everybody gets
21 upset with it, either pro or con.
22 I don't know quite how we circumvent it, but I do
23 think these are terms today that in legislation and other ways
24 are giving us lots of trouble.
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25 I thought Frank had some followup on his definition

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1 that indicated something. What was that? What was it you
2 said?
3 DR. BLAIR: I did include perception, however --
4 such areas as impaired perception, conceptualization, verbal
5 language development, reading, writing, numerical concepts,
6 spatial orientation, social perception.
7 DR. MYKLEBUST: There are many terms there in what
8 Frank just read that I would have to say in my own experience
9 simply aren't negotiable. You can't get it through anywhere.
10 It really includes everything under the sun, conceptualization,
11 perceptual processes.
12 Now, the way it is being done sometimes is to say
13 you mean it includes conditions commonly referred to as
14 aphasias, dyslexias, and so on. Sometimes that goes in certain
15 situations.
16 Maybe we don't want them. Call them just verbal.
17 Then, instead of the perception, conception, and so
18 on, disturbance of-- And this gets into Harrie's term,
19 "disorientation," which is one of the most difficult today,
20 because disorientation in the field of learning disabilities
21 in many ways means people who don't know right from left,
22 can't learn time, and can't learn spatial concepts, disoriented
23 in space and so on.
24 So this term "disorientation" I would have to say

25 in many circles at least in learning doesn't mean what you

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1 mean at all.

2 DR. SELZNICK: No, I was thinking of maladaptive,

3 inability to handle --

4 DR. MYKLEBUST: This is what I mean. If we could get

5 away from some of these, we would have I think perhaps in most

6 situations better acceptance.

7 So I wonder if you get to the nonverbal if you want

8 to say something about these. If we want to list-- I don't

9 know how much we should list either. This is also trouble-

10 some. But you could say "such as," which has been done, of

11 course, several times. And then it gives sometimes quite a

12 list, and sometimes they give just a few.

13 But like time concept is disturbed, and that is

14 usually thought of as nonverbal. I mean it is disturbed in a

15 number. Spatial perception. Right/left orientation. And so

16 on. These are common nonverbal disturbances in this population

17 How do you want to proceed here. I think what we are

18 getting at here is how to say this to best say what we mean

19 and not cause too many people to be concerned or rejected just

20 because they don't get what we mean by the terms.

21 I don't want to jump ahead here now. Do you want

22 us to try to take all of these and write it a little different-

23 ly for tonight's session? Do you want to terminate a little

24 earlier and some of us work on this and see if we can get

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25 something that would work out for tonight?

1 DR. SELZNICK: Could we get copies of the several
2 suggestions that we could lay alongside?
3 DR. MYKLEBUST: That's what I was wondering. I don't
4 know whether I can get them duplicated tonight.
5 DR. BLAIR: Are you saying kind of a subcommittee
6 thing to --
7 DR. MYKLEBUST: Yes. I was wondering about that.
8 DR. RIDGWAY: Are you saying that-- I think I hear
9 you saying that we are fairly happy with this definition and
10 now we are talking about amplification --
11 DR. MYKLEBUST: Yes.
12 DR. RIDGWAY: -- of the definition.
13 DR. MYKLEBUST: Yes, taking this and what Frank has
14 presented and putting these together with one definition, of
15 course, and this does assume, Bob, that we feel we should go on
16 to that detail about it now.
17 It is going to take a little while to write this up
18 I think and get it into a form that might overcome some of the
19 problems that I feel would be very prevalent unless we do
20 watch the language and terms used.
21 Take the suggestions of all of you. Like Jim says,
22 what do you mean by developmental processes? And so on. And
23 what Sam says. It will be necessary, of course, to have some
24 statement of what we mean after we get this done. I think we
25 perhaps need more of a preamble, a rationale for it.

1 I don't know. How do you feel about it? Does this
2 sound like a way to proceed?
3 DR. WOLFE: I think the words "remediable" and "allev
4 ated" in the same statement might be questioned. Leaving out
5 "remediable" and putting in "remediated" for "alleviated"
6 would be much better grammatically.
7 DR. SELZNICK: What does it mean?
8 DR. MYKLEBUST: Yes, Phil?
9 DR. HATLEN: I had trouble reading this, so I rewrote
10 it for my own purpose.
11 DR. MYKLEBUST: All right. Can you all hear? We are
12 getting some traffic outside.
13 DR. HATLEN: This is taking this and rewriting it
14 so that I can understand it better myself.
15 Children with learning disabilities are those who
16 have had adequate learning opportunities, yet indicate re-
17 mediable deficits in developmental and educational processes.
18 These deficits may be minimized -- or what? -- eliminated or
19 remediated -- through special instructional techniques.
20 Learning disabilities are not primarily the result of sensory,
21 motor, intellectual, or emotional disorders.
22 That's the same thing as there except that I can
23 read it a little better.
24 DR. BLAIR: I think we are saying the same things
25 over and over. I think we are beginning to cover the same

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1 ground. I wonder if this subcommittee idea wouldn't make sense
2 to expedite things.
3 The Chairman might appoint a subcommittee that would
4 be willing to go to work on this.
5 DR. MYKLEBUST: Is that agreeable with everyone? Do
6 you want to proceed that way? How long a time shall we allow
7 here? We're going on towards four o'clock. Could this com-
8 mittee, do you think, have something ready for us by seven-
9 thirty tonight? Do you think you can make it?
10 (Discussion off the record.)
11 DR. KIRK: Is the committee going to include, follow-
12 ing a generalized statement, some specific delineation of edu-
13 cational, psychological, remedial, some of the words there?
14 Will the committee do that, define those?
15 DR. MYKLEBUST: I think so, but I'm not sure we'll
16 get it all in. I rather would like everyone to be working at
17 this, but the question is whether we are most efficient and
18 effective this way.
19 Corrine has something here too that I think an hour
20 or so ago sparked all this that seemed to have some very good
21 sentences in it. I think really the committee should be look-
22 ing at that in addition. It does have a little of what you
23 just mentioned I think.
24 What is that, Corrine?
25 DR. KASS: Children with deficits in learning which

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1 require special techniques and methods. These deficits mani-
2 fest themselves in difficulty in learning processes-- Oh, I
3 just added that. I was saying in learning developmental and
4 academic tasks. But I could say, instead, in learning processes
5 -- period. And then we could define those.

6 DR. MYKLEBUST: Developmental and academic learning.

7 Before we proceed, then, I do want to raise this ques-
8 tion again. The definition so far, so far as I understand it
9 now-- Please correct me, because maybe I'm missing it. But I
10 don't think, you see, the definition says anything about extent
11 of involvement, degree of involvement, and so on. Does it?

12 DR. DENO: You could add the word "significant" be-
13 fore "deficits." Then you have to define what "significant"
14 is.

15 DR. MYKLEBUST: You have heard Evelyn's suggestion.
16 I don't know how far this would meet our needs.

17 I suppose I could ask the question this way: Is
18 there anyone who feels that this has to be more specific in
19 terms of extent of involvement?

20 Now, Jim has-- Go ahead, Sam.

21 DR. KIRK: If you couched it the way we do in other
22 fields of the handicapped, such as a developmental deficit of
23 such a nature and degree that requires special remedial
24 techniques for its amelioration or alleviation-- In other
25 words, this requires special remedial technique, severe enough

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1 to require that.

2 If it can be handled in another situation --

3 DR. MYKLEBUST: Now, I like these general approaches

4 for now, and I am pretty sure that's probably the direction we

5 have been going all afternoon. I also do call your attention

6 to the fact that in most areas of handicapped today -- I think

7 I'm right about this -- you do have quantitative cutoff points.

8 Now, Corrine, are you assuming at all for any pur-

9 poses in your thinking that this learning disability involve-

10 ment can be quantified?

11 Now, I started to say that Jim, who has been working

12 on definitions in various ways with another committee, has

13 indicated-- May I quote you, Jim?

14 DR. CHALFANT: I'm not sure what --

15 DR. MYKLEBUST: The three grades. May I use them as

16 an example?

17 Well, I don't have to use yours. I have several of

18 my own.

19 DR. CHALFANT: That was --

20 DR. MYKLEBUST: The point here is that for as long

21 as I think we have had special education we have been saying

22 he's retarded educationally if he is down a grade, two grades,

23 three grades, et cetera. Now, Jim is suggesting something of

24 this type for some purpose. I am asking you if that is where

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25 you want to leave it, or don't you even want to say he is down

1 a grade? You don't want to say anything about how much he is
2 down?
3 DR. BLAIR: I suppose the question is whether this
4 basic statement has to include that or whether this doesn't go
5 beyond the basic statement into a more, let's say, embellish-
6 ment of the whole concept.
7 DR. SELZNICK: Looking at the application of this
8 statement to a school system, if we did call for a certain
9 number of grades' retardation in academic schools, it would
10 preclude the inclusion of the child who is identified very
11 early in the school career. It would mean the child would
12 have to experience two or three years of school failure be-
13 fore he could be located in a service by which we have already
14 determined he can benefit.
15 DR. HEWETT: You would have also the problem of the
16 validity of some kind of achievement measure and what you woul
17 use to find out -- whose impressions or what instrument.
18 DR. MYKLEBUST: Evelyn.
19 DR. DENO: It also assumes that schools are going
20 to stay in a graded system.
21 DR. MYKLEBUST: I'm not happy with grades. I am
22 saying what has been done. I don't use them. We use learnin
23 quotients and do get at the ratio of expectancy to achievemen
24 I am personally committed to the ratio and to the
25 very definitive. And in this way, as you know, under Public

1 Health, we are now through our second year of a massive study
2 in this connection of learning disabilities in the public
3 school system, and we have used the learning quotient concept,
4 and in this way we can now say if you take a learning quotient
5 of 80 you will have about 1 per cent of your school population
6 that tend to fall into this category. If you take 84 or 85 or
7 89, obviously you have more.

8 We have done similar things in the deaf, the blind,
9 and the retarded.

10 Now, what you are saying here, as I understand it --
11 and I'm not disagreeing -- is that at this time we prefer not
12 to get into the question of how much involvement. Now, this
13 does leave it wide open for anyone's interpretation in any way
14 whatsoever.

15 I think in proper diagnosis, as Sam has stressed --
16 and Bill's question -- and as you are all expressing -- we
17 probably still wouldn't include the gifted child who is under-
18 achieving. It does mean we would get evidence to the effect
19 that he is an under-achiever and not one without these problems.
20 That is, he does have some problems that can be manifested --

21 MISS TAYLOR: He has not had adequate opportunity
22 in school. We eliminated him right there.

23 DR. DENO: Right.

24 DR. BLAIR: How might you suggest that this be in-
25 cluded in our statement, Mike? Would you have a suggestion to

1 make?

2 DR. MYKLEBUST: Not at this point I don't. I would
3 rather see how we can say what we want to say here. This
4 doesn't give anyone any indication of incidence I don't think.
5 How can you? You haven't any idea how this is going to be
6 finally categorized in any given situation, how it's going to
7 be used, what criteria we are going to apply. So we give them
8 the tests, you see, as we have all suggested.

9 Well, what cutoff point on the tests are we going to
10 use?

11 Now, all of this is left out. And it might be wise
12 to do so. But I do point out that you have no indication
13 from this in terms of incidence.

14 Bob?

15 DR. RIDGWAY: We have another alternative, which is
16 the one Sam suggested, and that is to insert, in place of
17 "which can be remediable," the term "which must be" -- I think
18 I heard you say something to that effect -- which would define
19 these in terms of the processes used to take care of them
20 rather than in terms of how far -- you know -- how difficult
21 the problem is.

22 DR. KIRK: There is one problem about --

23 MISS TAYLOR: "Which requires."

24 DR. KIRK: -- an index, and that doesn't take us to
25 the pre-school level. Because if we can detect these children

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1 at four and five and really remediate them, then they won't
2 have the academic disability at an older age.
3 Now, we can get an index for school age kids, but
4 how are we going to get an index for pre-school kids?
5 DR. MYKLEBUST: Well, Sam, it depends on how you
6 want to do it, of course. You can get developmental indices
7 here. In the ratio concept, of course, you can take them at
8 any age, depending what it is you are measuring in learning.
9 You can get a learning quotient on walking or handedness or
10 any of these, so long as you can measure them.
11 But I am not suggesting we should do this. I'm sure
12 the group doesn't want to. But I do want to point out we have
13 done it. It's easy to do. You can get ratios on children
14 right down to birth.
15 But here you can't use walking and so on very well
16 I don't think. I don't think that would work too well.
17 I'm talking too much.
18 Jim, you're next.
19 DR. CHALFANT: I wanted to amend what you said. I
20 was not referring to grade levels when I talked about dis-
21 crepancies in functioning. This could be between the perform-
22 ance in a given process and the child's overall level of de-
23 velopment. Or it might be a discrepancy between one process
24 and the other, seven or eight processes, or however many there

25 are, rather than grade level, which is very closely related

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1 to the ratio idea that you mentioned.

2 DR. MYKLEBUST: All right. Now, --

3 DR. CHALFANT: But the --

4 DR. MYKLEBUST: Yes?

5 DR. CHALFANT: Then the question is: If this is a
6 child's level and he has a deficit of say a slight deficit
7 here, when does that constitute a learning problem? I mean
8 does he have to be-- How much of a difference between these
9 educational and developmental processes does there have to be
10 before you have a learning disability, and how much differ-
11 entiation is there among normal children?

12 DR. MYKLEBUST: This is my question, Jim. As we have
13 now done it, we haven't taken any position about this.

14 Jo?

15 MISS TAYLOR: Isn't it also true that in the motor
16 handicapped and the emotionally disturbed, for instance, you
17 have no calculator and that those working with visually and
18 auditorially handicapped children have been fighting for years
19 to get away from these same numerals that are medical or in-
20 dustrial and are transferred to education without meaning?

21 DR. MYKLEBUST: Well, I suppose you would have a lot
22 of different reactions to that. I wouldn't say so, no. I
23 think it is going quite in the opposite direction. We are
24 getting much more statistical about it in all branches that I
25 know.

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1 We are quantifying pediatric findings, neurological
2 findings, ophthalmological findings. Everybody is doing it.
3 I think it is much more in this direction of quantifying.
4 And maybe we have been fighting about it. But let's
5 face it. It's what we are going by. We are going by the
6 50 IQ, and we are going by the 80 db in deafness. And we
7 are going by the 20/200.
8 Now, again I repeat it is not just as individuals
9 but as society in schools. That is what I think we are doing.
10 We do use them, don't we?
11 And there are also the legal problems involved. I
12 am just trying to see problems. I don't think you can legis-
13 late about this definition we have come up with. They don't
14 know what they are dealing with. They have no idea of knowing
15 how many there are or what legislation would be indicated.
16 I don't think it's possible to legislate from a definition of
17 this kind.
18 DR. SELZNICK: I have in front of me the standards,
19 the rules and regulations of the State Department of Education
20 in Maryland. Because programs for children with learning
21 disabilities are financed in part by the State. $800 per child
22 per year is provided in Maryland.
23 "The local department of education shall provide a
24 special program within the public school system for any child
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25 whose specific learning disorder results in such impairment

or dysfunction of the intellectual processes that he cannot benefit from the instructional program usually found appropriate for most children. Specific learning disorders include, for example, problems in reception, cognition, symbolization and expression of language, problems in visual perception and integration, and a special reading disability.

"Where a group of children who have a special learning disorder can be brought together, a special class may be formed and a qualified teacher and aide employed."

And then it goes on to suggest the maximum numbers for classes.

This is very broad. They didn't find it necessary to spell out. And the State Legislature bought it.

DR. WOLFE: The first sentence includes the mentally retarded.

DR. SELZNICK: They have a separate section on that.

DR. WOLFE: I know, but let's say we are reading only that.

DR. MYKLEBUST: Yes, Bill?

DR. HELLER: Corrine mentioned this morning her first objective was the advantage of having a national definition. Now, is this advantageous, or is it advantageous to delimit and indicate the extent of the population? Because we are always asked how many at the U.S. Office of Education. How much does this include? What is the extent of this problem?

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1 DR. MYKLEBUST: That's right.

2 DR. KIRK: What do you answer for the mentally re-
3 tarded or emotionally disturbed?

4 DR. HELLER: Just about what you said the other day
5 at the meeting. The same thing that has been answered for the
6 last ten years. Because we have no up-to-date figures on this.

7 MISS TAYLOR: That is not included in it.

8 DR. KASS: No, it is not. But in order to get legis-
9 lation in the first place, you see, you have to give legislators
10 some notion of how many children are to be served, what the
11 needs are. And it seems to me at one point that some sort of
12 incidence was reported.

13 I think this in and of itself -- the definition in
14 and of itself -- will give nothing in relation to national
15 legislation unless there is some quantifiable extent, if for
16 no other purpose than to get this started.

17 It is unfortunate, of course, that we don't keep our
18 incidence figures up to date. We should. But I do know that
19 incidence figures are being quoted at the Office of Education.
20 As the consultant in this area I am not being consulted on this.
21 And it seems to me that this group ought to give some thought
22 to the numbers.

23 DR. BLAIR: I'm a little troubled. I sense a shift
24 in our direction. We were talking earlier about a definition
25 for special education, and now we are talking about what the

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ERIC

1 legislators are going to read. It seems to me there are two
2 different approaches here.
3 DR. MYKLEBUST: Well, I'd like to compromise here
4 what I think we are getting, Frank. I think what we are saying
5 is not at all discrepant with the idea for education. I do
6 think there is one thing that is discrepant, and that is the
7 pre-school, Sam. You and I and others would like pre-schoolers
8 included, but that depends on how you define pre-schoolers.
9 If you say special education, you are talking about
10 school age children. Then we could leave out developmental,
11 and so on, which I believe is going to be troublesome if we
12 want acceptance, which we do.
13 However, if you want it in, we leave it. But special
14 education doesn't go down below four, five, three. I don't
15 know. It depends on where you are. This I think is one of the
16 things here.
17 Now, the other is that as special education people
18 we are trying to get something that would be useful for legis-
19 lative purposes. I think even in special education-- Let's
20 ask Harrie. Harrie, how many do you have by your definition
21 in your State law?
22 DR. SELZNICK: Well, we know specifically of approxi-
23 mately 200 such youngsters out of a total pupil population of
24 194,000.
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25 DR. MYKLEBUST: Which would be a percentage of what?

ERIC

1 DR. WOLFE: One per cent.

2 DR. SELZNICK: It is less than 1 per cent.

3 DR. MYKLEBUST: Now, you see, Harrie's criterion here
4 would be a very severe one. These would be children, in terms
5 of studies that we have done and I think other people are
6 going by-- It would be very limited, very severe.

7 You can take this at cutoffs all the way up to less
8 severe youngsters.

9 Now, would this be what would be useful here for
10 some purposes? Could we do as many people are doing, as
11 Corrine says in Washington, and certainly they are doing it in
12 Denmark and many other places? They just simply say, "We know
13 there are about these many." Now, you make assumptions about
14 criteria. You don't spell them out.

15 For example, you can say that you think there are
16 children up to 2 per cent or 3 per cent or 4 per cent who
17 would fit what we have said as a group if we agree on the per-
18 centage we would want to use. We could do it this way if you
19 want to put it in.

20 MISS TAYLOR: Isn't that type of information usually
21 given in hearings rather than being part of a definition?

22 DR. MYKLEBUST: Yes, I think so.

23 MISS TAYLOR: So that really we are asking for a
24 separate thing now. We are asking for additional information
25 that would be helpful to somebody in hearings before either

State or Federal legislative committees.

DR. MYKLEBUST: Well, I suppose I am. I suppose that's the right way to state it, Joe. I just want to be clear that, as I see this, the application here could eliminate everybody. Harrie is eliminating everybody but 8/10ths of 1 per cent or something.

Now, that's Harrie's prerogative. He can use it any way he wants to.

Is that where we leave this now so that everyone applies it this way without any indication of extent of involvement?

DR. BLAIR: I think, Harrie, you are saying this programming you have involves 200 children, but this does not mean that you --

DR. SELZNICK: There may be many other children.

DR. BLAIR: -- don't have precise figures.

DR. SELZNICK: My budget is the controlling factor.

DR. RIDGWAY: Sam suggested 69 as a cutoff point for mentally retarded.

DR. KIRK: That's how it started. Then they went up to 75, then up to 80. Some places they were going up to 85.

We find when you get higher kids they regress to the mean of the group. So if you put the 85 with the 60, they don't get so much progress. So you begin to cut back.

If you want to be conservative, you can take a small

1 percentage to start with to not scare the legislators, and then
2 as studies are made you get the-- Well, for speech correction
3 they estimate 5 per cent, 8 per cent, 3 per cent, whatever you
4 want. What are these? Little articulatory disorders that the
5 kid is going to get over a little later anyway. And they con-
6 centrate on those.

7 And the practice of speech correction in the public
8 schools today says you have got to have a caseload of 100 or
9 150. So what do the poor little speech correctionists do?
10 They get the minor cases, give them a shot in the arm one day
11 a week or two days a week, and within a year they get over it
12 anyway.

13 But the severe cases she runs away from because they
14 take five or ten hours a week, and they don't have that much
15 time.

16 Do we start with the minor ones so we can show we have
17 a caseload of so many and get out? Or will we hit the ones
18 that everybody is running away from?

19 It's a matter of judgment here. And where do you
20 start and where do you end?

21 Now, you apparently got these very severe cases where
22 the parents are saying, "Harrie, you won't put them in this
23 class or this class. My kid is six years old, can't talk.
24 My kid is ten years old. He hasn't learned a word."

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25 So you take the more severe ones. If you have 200,

1 that's the absolute minimum to me. Isn't that right?

2 DR. SELZNICK: You're right. But, you see, what we

3 are not talking about in addition is the manner in which we are

4 going to try to serve them, which relates specifically to the

5 number you identify, the number you serve.

6 In many communities these youngsters are being re-

7 tained in regular grades with an itinerant service being brought

8 to them for part of the day, like speech correction service or

9 lipreading service, et cetera.

10 Now, the youngsters whom we are specifically serving

11 are youngsters with severe enough problems to remove them from

12 the regular stream for the major portion of the day and have

13 them with a special teacher applying special techniques and

14 special equipment, et cetera, for practically the entire day.

15 DR. KIRK: Those are the 200?

16 DR. SELZNICK: The 200.

17 DR. MYKLEBUST: Yes, this, of course, is very appro-

18 priate. Now, I do want you to check me on this though. Am I

19 wrong about this in coming back to Jo's question? Couldn't you

20 interpret this up here as being any child in any school?

21 Because you haven't indicated anything by way of even "signi-

22 ficant," Evelyn. Shall we put in "significant" or what?

23 Something specific, special?

24 Oh, yes, it's degree that requires special techniques

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25 for remediation, isn't it. Oh, yes.

ERIC

1 DR. HELLER: We don't have "which require." We say
2 "which can be."
3 MISS TAYLOR: "Which require" it should be.
4 DR. MYKLEBUST: Now, that gives us an out, doesn't
5 it?
6 DR. DENO: Yes.
7 DR. MYKLEBUST: Sure.
8 DR. DENO: The word "adequate" educational opportun-
9 ity defines a reasonable, regular program. It places some res-
10 ponsibility. And then the fact that the child requires some
11 kind of technique which is not feasible to apply within that
12 regular program is another defining element in here.
13 DR. MYKLEBUST: Yes, it is. That's good. That lets
14 me off. That's fine, folks. That I think will hold. I think
15 it will hold.
16 DR. KIRK: You mentioned, Mike, eliminating develop-
17 mental.
18 DR. MYKLEBUST: Yes.
19 DR. KIRK: I wonder about that. Because kinder-
20 gartens are more common, and that's pre-school. With Head
21 Start they are starting at four.
22 DR. MYKLEBUST: That's right.
23 DR. KIRK: With the whole push we have, we are
24 probably going to have kids four, five, and six years old.
25 When you come to "educational," you're thinking of second-grade

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1 and above, because you don't know they are retarded. So you
2 are eliminating three age groups.
3 So for that reason I believe I would retain devel-
4 opmental.
5 DR. MYKLEBUST: Fine.
6 DR. SELZNICK: We have been serving youngsters from
7 two and a half on up in the areas of the deaf and in the areas
8 of the severely physically limited.
9 DR. MYKLEBUST: Yes, I know. Not in this area yet is
10 what I meant, Harrie.
11 DR. SELZNICK: No.
12 DR. MYKLEBUST: But you probably will very soon.
13 MISS TAYLOR: Why not?
14 DR. DENO: Can't you say something like "sufficiency
15 in the development of"?
16 DR. MYKLEBUST: I think this is --
17 DR. DENO: In developmental tasks. This takes out
18 an age factor that puts in developmental tasks typical for
19 the age level, which is what you want. And you want a sig-
20 nificant deficiency in the development of competencies which
21 are related to those developmental tasks. I think that's --
22 DR. BLAIR: I don't like this definition on the
23 board. I'm going to be very frank about it.
24 DR. MYKLEBUST: Well, Frank, we are talking about
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25 all of these combined.

1 DR. BLAIR: All of these combined?

2 DR. MYKLEBUST: We are talking about the one you have,

3 Corrine's, and this, as one.

4 DR. BLAIR: Fine.

5 DR. MYKLEBUST: I'm talking about this as one unit

6 yet to be put together.

7 DR. BLAIR: Fine. Okay.

8 DR. MYKLEBUST: Well, are you satisfied now if we

9 go ahead and try to put them together?

10 DR. ASHCROFT: Yes.

11 DR. MYKLEBUST: And then I am going to ask a few

12 people to do it. I was concerned about this extent problem,

13 and I see now that we have something which does mean he is

14 a special child because he requires special help, Corrine.

15 DR. KASS: Yes.

16 DR. MYKLEBUST: I know you all want to work on this

17 committee. And if you do, we will be happy to have you

18 volunteer. I will have to start by appointing some people.

19 Frank and Evelyn have been working on it. Will you

20 serve on it? Lou? Corrine, can you help with it?

21 DR. KASS: Yes.

22 DR. MYKLEBUST: Jim. you have something that you

23 have been working on.

24 We have five. Would you five people then get to-

25 gether?

ERIC

1 (Discussion off the record.)

2 DR. MYKLEBUST: Do the rest of you have any questions

3 you want to carry on with, or do you want to take a break and

4 come back after dinner?

5 DR. FLIEGLER: I'd like to ask you one question in

6 terms of your formula which is intriguing and hopefully we're

7 not going to miss it. If you substituted "achievement level"

8 rather than "grade level," is this what you were really trying

9 to get at?

10 DR. MYKLEBUST: Yes.

11 DR. FLIEGLER: If you were to push this point, is it

12 possible in terms of your work-- And I'm going to the pre-

13 school concept here. Would it not be possible to arrive at

14 some composite figure or statistic which is global and get that

15 achievement level for the pre-school youngster? Is this what

16 you were getting to?

17 DR. MYKLEBUST: I think it is quite possible, yes.

18 That term isn't good there. And it probably is the weakest

19 thing in the formula at this time. Because standardization in

20 this connection and theoretical constrict are not very good.

21 But we have covered I think what there is.

22 It is going to take some doing I think to extend this

23 on more theoretical bases and down to the lower age levels and

24 so on.

25 So far as we can see at this time as a rationale it

1 would be quite possible to do what you are asking.

2 Anything else? Questions? Bill?

3 DR. WOLFE: I have taken the last part of the first

4 sentence and changed it around a bit. Let me try this on you

5 for the committee's benefit.

6 DR. MYKLEBUST: Go ahead

7 DR. WOLFE: The first part would read, "Children with

8 learning disabilities are those who have had adequate learning

9 opportunities in home and in school but yet present deficits

10 in developmental, educational, and psychological processes so

11 severe that special remedial techniques are required."

12 That puts it right into our bailiwick.

13 DR. MYKLEBUST: That's right. I think this concept

14 has to be dealt with.

15 DR. WOLFE: But "so severe" would be the point that

16 I think would throw it into special education.

17 DR. MYKLEBUST: Fine. Any other suggestions for

18 the committee?

19 MISS TAYLOR: I think the word "discrepancies" --

20 DR. WOLFE: Would be better than "deficits."

21 MISS TAYLOR: Yes.

22 DR. WOLFE: Yes.

23 DR. KIRK: Developmental discrepancies?

24 DR. WOLFE: But yet present discrepancies in develop-

25 mental, educational, and psychological processes.

1 DR. RIDGWAY: Discrepancy can be either direction;
2 deficit can be only one.
3 DR. KIRK: Why not developmental discrepancies in edu-
4 cational and psychological processes? Developmental discrepan-
5 cies in psychological and educational processes?
6 DR. MYKLEBUST: I think this has been taken down here
7 as a suggestion for the committee. We'll see what they can do
8 with it.
9 Anything else for the committee?
10 DR. DENO: You use the term "so severe," which has
11 a connotation for me which it probably shouldn't have, but it
12 is just a continuum of disability, and one of the things in
13 here --
14 DR. WOLFE: Depending on whether we think they are
15 10 per cent or 2 per cent. We are only concerning ourselves
16 right now with the lesser of the two percentages I thought.
17 DR. DENO: Oh. Well, the rest of your sentence goes
18 on about "so severe that special techniques" --
19 DR. WOLFE: That special remediable techniques are
20 required.
21 DR. DENO: Well, it's a more qualitative thing
22 maybe than severity on a continuum. Like a totally blind child
23 might require almost no accommodation at all once he has
24 learned Braille. But there is a character of something in
25 here rather than a severity on a continuum. But maybe that's

1 nit-picking.

2 DR. SELZNICK: No, it's important.

3 DR. DENO: Because the important element is that this

4 requires something which is not feasible to incorporate in the

5 offerings of the regular program. That is the whole concept

6 of the child not being able to achieve adequately under the

7 program of instruction ordinarily applied. And it ordinarily

8 has to be a reasonable offering.

9 DR. RIDGWAY: The committee can decide whether "dis-

10 crepancy" means either up or down.

11 DR. DENO: I'm nervous about the "discrepancy" and

12 even intra-individual discrepancies. Because that immediately

13 suggests it is nice for people to be even in everything. And

14 I'm willing to let a kid practice for ten hours if he is a

15 genius on the piano.

16 DR. RIDGWAY: I'm speaking to "deficit" rather than

17 "discrepancy."

18 DR. BLAIR: Discrepancy between expected and actual

19 achievement. I think you have covered it. I don't think there

20 is any problem here.

21 DR. DENO: I think we should keep it all on manifest

22 behavior level.

23 DR. WOLFE: Do we come back here tonight?

24 DR. MYKLEBUST: The schedule -- I hope you don't mind

25 -- calls for us to come back tonight. And I think to get this

1 definition problem resolved-- I think we have made a lot of
2 progress on it. I think we have to do this tonight.
3 DR. WOLFE: To this room is what I am talking about.
4 DR. MYKLEBUST: Well, yes. How about seven-thirty?
5 We'll set a limit of two hours on it.
6 DR. RIDGWAY: May I ask a couple of questions about
7 tomorrow? I apologize for bringing up the fact we have to leave.
8 DR. MYKLEBUST: Go ahead.
9 (Discussion off the record concerning arrangements.)
10 (Whereupon, at 4:15 p.m., the meeting was recessed,
11 to be reconvened at 7:30 p.m., this date.)
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1 **E V E N I N G   S E S S I O N**

2 7:35 p.m.

3 DR. MYKLEBUST: Well, you people are to be commended
4 for your promptness tonight. I greatly appreciate your coming
5 in like this right on time.

6 Now, the committee worked assiduously here, and they
7 have a definition statement for your consideration.

8 As you know, they have tried to incorporate the basic
9 aspects of all of the definitions and discussion that went on
10 here this afternoon.

11 Now, the wording of the statement is here on the
12 slate. Would you take first just a minute to read it through
13 all the way before we begin discussing it?

14 Do you want to have Evelyn Deno read it for us as
15 a group? Or shall we just take a minute for everyone to read
16 it through? I did agree that I would try to have copies made
17 tomorrow. Meeting at eight o'clock in the morning I won't have
18 them for you.

19 If you can, it might be a little easier if you would
20 copy it down, because I will be delayed in getting copies ready
21 for you tomorrow morning.

22 (Reporter's note: The statement prepared by the Sub-
23 committee follows:

24 "A learning disability refers to one or more
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25 deficits in essential learning processes requiring remediation

1 through special educational techniques.

2 "Essential learning processes are those currently
3 most commonly referred to in behavioral science as perception,
4 integration, and expression, either verbal or nonverbal.

5 "Deficits are to be considered significant in terms of
6 accepted measurement procedures in education and psychology.

7 "The learning disability referred to is not primarily
8 the result of sensory, motor, intellectual, or emotional handi-
9 cap, or lack of opportunity to learn.

10 "Children with a learning disability generally
11 demonstrate a significant discrepancy between expected and
12 actual achievement in one or more areas, such as: spoken,
13 read, or written language, mathematics and spatial orientation."

14 DR. WOLFE: It sure covers the waterfront, doesn't it?

15 DR. MYKLEBUST: So did the discussion, Bill.

16 DR. WOLFE: I don't doubt that a bit. Looking at the
17 committee, I don't see how you got through.

18 DR. MYKLEBUST: Well, it was a real discussion. The
19 committee really did a job in getting it together here.

20 DR. ASHCROFT: When you are ready, I have one comment
21 I would like to make.

22 DR. MYKLEBUST: All right, we'll be ready in just
23 a minute, Sam. I think most people are pretty well through it.

24 Dr. Ashcroft is ready with a comment, so will you go

25 ahead, Sam?

ERIC

1 DR. ASHCROFT: First of all, this is I think a very
2 fine statement, remarkably complete and well-phrased.
3 I have had a continuing concern over the past several
4 years, however, in this area. I wonder if it's worth mention-
5 ing. And I don't know what can be done about it. I don't
6 know that I have a specific recommendation to give.
7 But in the last several years we have been sensitive
8 to a lot of concerns about the traditional ways we have defined
9 children for educational purposes. The thought essentially is
10 this: What can we do at this point when we have an opportunity
11 to phrase a definition and to identify a group of children to
12 avoid some of the kinds of problems that we have fallen into
13 with other groups of children? And I am thinking specifically
14 of organizing the community's response to a child that they
15 have concerns about. The concern, though we see it is wide-
16 spread, is not universal.
17 But we're going to do something to focus, to identify,
18 to perhaps label another type of child, and I wonder what con-
19 siderations we should think about in that connection at this
20 juncture?
21 DR. MYKLEBUST: Does anyone care to comment?
22 (No response.)
23 I don't want to put Corrine on the spot here. It
24 would seem to me that probably Corrine faces as big a problem
25 as any of us, more than most of us, in this connection. Do you

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1 have any comment at all?

2 DR. KASS: I think I'd have to say that in many com-
3 munities in many places that I visit I find that there is an
4 attempt to get together on the needs of a community.

5 At your own place, for example, George Peabody, I was
6 in a meeting with university personnel, local school people.
7 I don't know if there was a State person there or not.

8 Is this what you had in mind, Sam?

9 DR. ASHCROFT: Yes, partly. I think it's professional
10 identification and also lay identification of children.

11 DR. DENO: You didn't mean that this definition isn't
12 capable of being enough of a tear-jerker, did you?

13 DR. ASHCROFT: No, not at all. I want to avoid that
14 kind of thing.

15 DR. DENO: Right.

16 DR. ASHCROFT: I wasn't speaking to this definition
17 at all. I'm speaking to the general movement.

18 DR. DENO: Well, my own feeling about this area and
19 why this definition seems satisfying to me personally is be-
20 cause I have the same concerns. The way we have defined prob-
21 lems in the past has not been directly translatable or rele-
22 vant to education in the public mind. We have to build in a
23 lot of bridges in order to get from that over to this.

24 It just seems to me that what we have done here is
25 cast this very much in an educational frame of reference just

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1 by the term "learning disability" to begin with and saying that
2 the nub of it is in some deficit in essential learning pro-
3 cesses and then saying that people have a responsibility to
4 define what they are talking about in terms that are publicly
5 communicable, which is what that statement says to me:
6 "Deficits are to be considered significant in terms
7 of accepted measurement procedures in education and psychology."
8 This takes it out of the bailiwick of medicine, you
9 know, but puts it in dimensions which are translatable and rele-
10 vant for education. And then the other limiting parameters in
11 there.
12 And we have gone through this. We are going through
13 it right now. For instance, I just a couple of weeks ago at-
14 tended a meeting which some parents and some professionals who
15 were a little mixed up I think had generated, where they were
16 talking about developing a new parent organization.
17 We just had the Minnesota Association for the Brain-
18 Injured convert itself to going into the ballpark with the
19 Association for Children with Learning Disorders. And this
20 had been accomplished, you know.
21 Well, now, this group comes over the horizon and
22 wants to establish an Association for the Education of Children
23 with Language Learning Disabilities. You know. This has gotten
24 a big play in the papers.

25 And in the process of talking about this they were

1 talking about different school systems that have no program at
2 all for these children, and they are talking about school sys-
3 tems where I know that isn't true. So if you ask them and
4 pin them down, they say what they really mean in that the
5 school system is not using the term "dyslexia" and is not in-
6 structing children by the Orton-Gillingham Method.

7 I think if professionals are a little clear and have
8 a common frame of reference in which they can talk, then we
9 can talk better to lay people and we can communicate this to
10 legislators. They understand it. It comes down to the terms
11 that everybody understands -- spoken, read, and written language,
12 mathematics, and so on and so on and so on.

13 It kind of works through and comes down to specific
14 outcomes which are in everybody's language.

15 DR. MYKLEBUST: At the risk of sounding redundant,
16 I think the comment is very well taken. And if we as pro-
17 fessionals can come up with something that is workable, I
18 think, Sam, we will avoid some of the problems which are al-
19 ready presenting themselves. I really think it could be a mile-
20 stone.

21 Who else wants to comment? Bob?

22 DR. RIDGWAY: As I read your first sentence, I am
23 just very pleased with this. But when I read the third one,
24 I am not real certain what it means and how people can inter-
25 pret it or how it will be interpreted.

1 Could some of the people on the committee speak to
2 this?
3 DR. MYKLEBUST: Surely. I'm sure they would be glad
4 to. You are talking about the one starting off, "Deficits are
5 to be considered significant. . ."?
6 DR. RIDGWAY: Yes.
7 DR. MYKLEBUST: Corrine, go ahead.
8 DR. KASS: I think you're right. I sort of antici-
9 pated this. Initially, as we wrote this, the first sentence,
10 we had in mind to define the terms in that sentence that needed
11 defining, and these turned out to be two terms -- "deficits"
12 and "essential learning processes."
13 So that initially we had the two definitions, deficits
14 here, essential learning processes here. And somehow in the
15 process of fixing this up grammatically and smoothing it out,
16 we transposed these two terms.
17 DR. DENO: I don't know if I understand what you mean.
18 I think what we intended was to say by that sentence that this
19 deficit should be describable in some terms which are pro-
20 fessionally acceptable.
21 You know, we should be able to operationally define
22 this in some way that the professions themselves accept and
23 leave the door open here for changes in measurement procedures
24 and all kinds of --

25 DR. KASS: I think I can add to that explanation.

1 The deficits are in the essential learning processes
2 not in the manifestation of this.

3 DR. RIDGWAY: I was trying to read this as some of
4 the people on our faculty might. And I can see somebody sayin
5 "Well, what are you talking about? If you are talking about
6 measurement procedures, then do you mean statistically sig-
7 nificant"?

8 DR. KASS: Yes.

9 DR. RIDGWAY: I know you don't, but --

10 DR. KASS: Why not?

11 DR. RIDGWAY: Are you talking about the 05 level or
12 something like this?

13 DR. MYKLEBUST: It wasn't read into this I think I
14 could say, but it could be if you want it to.

15 DR. RIDGWAY: And I didn't particularly want to. I
16 thought it meant a significant deficit in terms of the way we
17 measure outcomes of education.

18 DR. DENO: Yes.

19 DR. MYKLEBUST: Yes.

20 DR. DENO: That's what it is supposed to mean.

21 DR. KASS: It's not what I would mean.

22 DR. DENO: Oh.

23 DR. MYKLEBUST: All right.

24 DR. KASS: If I may explain the difference again --

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25 DR. MYKLEBUST: Go ahead.

1 DR. KASS: -- between the deficit in the process and
2 the outcome, that is, the achievement tests, I think these are
3 two different things.
4 DR. RIDGWAY: Okay. Now let me back up, because I
5 agree with you there, and I see the difference that you mean.
6 But I think I see it because I am here and have participated
7 in this discussion and others. But I am saying that somebody
8 else who doesn't know that we are talking about process all the
9 time when reading this definition and saying deficits are to
10 be considered significant in terms of measurement procedures --
11 DR. KASS: Would it help to put this back up as the
12 initial term?
13 DR. SELZNICK: No.
14 DR. RIDGWAY: No.
15 DR. KASS: All right. Then it would have to be
16 deficits in learning process are to be considered.
17 DR. ASHCROFT: Would it help to put there "accepted
18 appraisal procedures"?
19 DR. DENO: I think maybe.
20 DR. HEWETT: "Measurement" is the difficult word,
21 because measurement cuts across so many statistical and re-
22 search kinds of things.
23 DR. RIDGWAY: With "significant" and "measurement"
24 together I think you are going to confuse some people. I know

25 what we mean.

ERIC

1 DR. WOLFE: "Diagnostic" would even be better, would
2 it not?
3 DR. HEWETT: Yes, it would.
4 DR. MYKLEBUST: Accepted diagnostic procedures in
5 education and psychology? How about that?
6 MISS TAYLOR: I think you could eliminate the word
7 "significant."
8 DR. MYKLEBUST: Excuse me, Jo. Lou, you were on the
9 committee. Do you agree?
10 DR. FLIEGLER: That's an excellent qualification, yes.
11 DR. MYKLEBUST: I think it's very well taken.
12 MISS TAYLOR: It seems you could eliminate the word
13 "significant," and that would avoid getting confused with
14 statistical.
15 DR. MYKLEBUST: With the term "diagnostic" in, I
16 think we feel it is relieved. How does the committee feel
17 about that? I think the feeling was that it wanted to stress
18 that there should be real indications by these diagnostic
19 procedures, and this is what the term "significant" was put
20 in there for. Am I right on that?
21 DR. BLAIR: Yes.
22 DR. RIDGWAY: I saw two ways to do it. This is one.
23 Another would be to say that learning disability refers to
24 one or more significant deficits in such and such, and then

25 say significant deficits are to be considered in terms of

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1 diagnostic procedures or something like that. This is another
2 way to do it.
3 DR. MYKLEBUST: Yes.
4 DR. RIDGWAY: I'm not suggesting it as preferable to
5 this one.
6 DR. MYKLEBUST: Well, as a group, now, what do you
7 like? I like this "significant" up there. I'm just trying to
8 get reaction here. What do you think? Refers to one or more
9 significant deficits in the first sentence now?
10 DR. HEWETT: I think that is preferable, because
11 "deficits are to be considered significant" sort of takes the--
12 Well, you're going to make a value judgment after looking at it
13 rather than looking at it initially as a significant deficit or
14 not.
15 DR. MYKLEBUST: We'll put "significant" in there
16 in the first line if you all agree.
17 Then, down here where it starts "Deficits," then
18 "significant deficits" there, Bob?
19 DR. RIDGWAY: Or it could be just plain "deficits"
20 are to be considered in terms of accepted diagnostic procedures
21 DR. MYKLEBUST: I think it would be a little redundant
22 there.
23 DR. DENO: Considered or described are you trying to
24 say?
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25 DR. MYKLEBUST: Now, just a minute.

1 DR. CHALFANT: In your first sentence, you have
2 "significant deficits" preceding your "learning processes."
3 I was wondering if you would want to interchange the second
4 sentence and the third sentence to be consistent with the se-
5 quence.

6 DR. MYKLEBUST: Yes. Now, Evelyn, do you want to make
7 your comment again? I think we lost it.

8 DR. DENO: No.

9 DR. KASS: You said another word for "considered"?

10 DR. DENO: I wondered whether he wanted "deficits are
11 to be considered" or deficits are to be described" in terms of.

12 DR. HEWETT: Or "determined."

13 DR. DENO: Or "defined."

14 DR. HEWETT: Or "defined."

15 "Considered" makes it sound a little vague.

16 DR. DENO: Like we kind of sit there and admire the
17 problem or something.

18 DR. MYKLEBUST: How about "defined"?

19 DR. DENO: That's fine.

20 DR. MYKLEBUST: Good. Okay. All right.

21 DR. DENO: Because that puts the onus then on the
22 judge. Right?

23 DR. CHALFANT: One other thing. Now, the essential
24 learning processes-- We have the deficits. Now, would you

25 want to move "children with a learning disability generally

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demonstrate a significant discrepancy" closer to the rest of the body and take your negative term and put it at the end?

DR. MYKLEBUST: Say that again, Jim.

DR. CHALFANT: Well, interchange the last and the next to the last sentences.

DR. MYKLEBUST: Yes.

DR. CHALFANT: Because your deficits reflect themselves in these language areas and spatial orientation. And then as a trailer you could put on-- It seems to me that the next to the last sentence intervenes with the last one. I would switch the two. But --

DR. MYKLEBUST: All right. Some more consensus here? So we interchange the last two sentences. Is it clear and more logical? Does it flow better?

DR. BLAIR: I think it does.

DR. MYKLEBUST: Interchanging the last two sentences? Harrie?

DR. SELZNICK: I was starting from the very beginning The opening sentence refers to a learning disability.

DR. MYKLEBUST: All right.

DR. SELZNICK: Then the last sentence I like personally as a followup, because you are still referring to the learning disability and how it is demonstrated, and so it is an expansion on the initial sentence. Then moving on to the next to the last sentence. And then finally going to the other

1 two.

2 It's a personal preference, thinking of the sequence

3 and the continuity.

4 DR. MYKLEBUST: Let's see if we have Harry's sug-

5 gestion. Corrine, did you get it? I'm not sure.

6 DR. KASS: Yes.

7 DR. SELZNICK: 1, 2, 3, 4, 5 (indicating sequence of

8 paragraphs desired).

9 DR. MYKLEBUST: Do you want to try that?

10 DR. KASS: A learning disability refers to one or

11 more significant deficits in essential learning processes re-

12 quiring remediation through special educational techniques.

13 Children with a learning disability generally demon-

14 strate a significant discrepancy between expected and actual

15 achievement in one or more areas, such as: spoken, read, or

16 written language, mathematics and spatial orientation.

17 The learning disability referred to is not primarily

18 the result of sensory, motor, intellectual, or emotional handi-

19 cap, or lack of opportunity to learn.

20 Deficits are to be defined in terms of accepted

21 diagnostic procedures in education and psychology.

22 Essential learning processes are those currently

23 most commonly referred to in behavioral science as perception,

24 integration, and expression, either verbal or nonverbal.

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25 DR. WOLFE: That reads much better.

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1 DR. KASS: Yes.

2 DR. MYKLEBUST: Yes, it does.

3 DR. HATLEN: Okay.

4 DR. HEWETT: It says "requiring remediation." Does
5 that really say it is possible to remediate? They require re-
6 mediation, but you may not be able to achieve that particular
7 goal. I'm just wondering if the point is really clear.

8 DR. MYKLEBUST: In other words, you are agreeing with
9 Harrie that something --

10 DR. HEWETT: Yes.

11 DR. MYKLEBUST: But you don't object to it there, do
12 you, Frank -- "requiring remediation"?

13 DR. HEWETT: No, but it may need clarification, be-
14 cause one of the original premises was that these deficits do
15 be actually dealt with.

16 DR. MYKLEBUST: I think that's right.

17 DR. DENO: If you added the phrase "for its relief,"
18 that would do something at the end of the sentence.

19 DR. CHALFANT: Dr. Kirk was talking about ameliora-
20 tion earlier.

21 DR. MYKLEBUST: Could I back up a little bit, inter-
22 preting Harrie's comment? I'm not sure you mean this. But
23 I thought you meant, as the committee did-- They took key
24 words out and made a sentence descriptive of or definition or
25 indicating the meaning of this word. I thought Harrie meant

1 that we should have a sentence about remediation. Is that what
2 you mean, Harrie?
3 DR. SELZNICK: That's as a carryover.
4 DR. MYKLEBUST: Not one word "amelioration" in the
5 context but a sentence like we did with "deficits," "essential
6 learning processes"?
7 DR. HEWETT: I think the term "requiring" is still
8 going to be a hang-up. "Requiring remediation" doesn't actually
9 imply you are going to be successful. It's the "would be nice
10 if you could" kind of thing.
11 DR. MYKLEBUST: If you add a sentence, wouldn't that
12 do it? That's what I'm hoping it would do.
13 DR. BLAIR: I guess we are not always successful
14 anyway.
15 DR. MYKLEBUST: Frank, you recall the reason for that
16 is that that is a way of getting it out of normal children --
17 because now you are dumping it right into special education.
18 The involvement is of sufficient impact to this child that he
19 needs special education.
20 Now, that's what this statement is intended to say,
21 isn't it?
22 DR. HEWETT: Then follow it up with something saying
23 it is possible to do what is expected.
24 DR. MYKLEBUST: I think it is very well taken. Cor-
25 rine already has it.

1 DR. HEWETT: You might want to get rid of that
2 second "significant." Generally demonstrate a "significant"
3 discrepancy. It may not be necessary if you are going to change
4 this. You have two "significants" coming very close together.
5 The "discrepancy" I think kind of alludes to the fact it's sig-
6 nificant after that first one.
7 DR. KASS: So we take out "significant" here?
8 DR. HEWETT: I don't think it's significant after
9 you have that first one in, if you keep it in that order.
10 DR. MYKLEBUST: Yes. Would you number the sentences
11 for us, please?
12 All right. Now you see the revision. Any other com-
13 ments? Bill?
14 DR. WOLFE: Mike, what would the addition of the word
15 "specific" before "learning disability" do to us and to the
16 field and to the definition? It's making it something special
17 in a way.
18 DR. MYKLEBUST: I want others to comment. You asked
19 me, and I will be glad to react to it. The term "specific"
20 here has, of course, been used in many different ways in this
21 country and in Europe, and I know I sound grandfatherish and
22 so on. I have heard it in so many committee meetings, cussed
23 and discussed, and so on, that my opinion is that it would add
24 difficulty, not clarification.

25 DR. WOLFE: Well, I take the suggestion from the word

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"significant" here. We have used it about three times. I know we have removed it a couple of times.

DR. BLAIR: Bill, one concern I would have would be that many of these problems are not specific. It seems to me that is what makes it troublesome.

I think if we were to add a word, as the State of Wisconsin has done, it would be "special learning disabilities," which I think is something you can live with because they are special.

But as to whether or not they are specific I think there is a real question.

DR. CHALFANT: The "one or more" takes care of the specific and the less specific disability also.

DR. MYKLEBUST: Yes, Harrie?

DR. SELZNICK: I'm referring back to the original invitation to this fine meeting where there is a reference to the development of guidelines for professional training in the areas of -- et cetera. And then I go to that opening sentence, and I see the word "remediation," and I wonder if in this statement there should be something about what we mean by remediation. Because it then opens the way to the guidelines that might be developed.

DR. MYKLEBUST: Yes.

DR. HATLEN: Does remediation infer that learning disability can be minimized or alleviated?

1 DR. KASS: Remediation means that these deficits can
2 be alleviated given techniques based on diagnosis -- something
3 on that order.
4 DR. CHALFANT: Are amenable to remediation.
5 DR. KASS: The idea is that the techniques must be
6 based on the diagnosis. I mean these are not just any remedial
7 techniques.
8 DR. HEWETT: Deficits can be corrected in a sense by
9 means of special techniques based on diagnosis or-- I don't
10 want to use "remediation" again, but --
11 DR. MYKLEBUST: May I suggest in Corrine's statement
12 here, apropos of the whole discussion today and various other
13 discussions that various of us have been in, I would like to
14 stress educational remediation here.
15 DR. KASS: Okay. Educational.
16 DR. MYKLEBUST: In other words, not just remediation,
17 but educational remediation.
18 Now, then, if you start with that, then what do you
19 have, Corrine?
20 DR. KASS: Then you have remediation means that these
21 deficits can be corrected --
22 DR. MYKLEBUST: Educational.
23 DR. KASS: -- by educational techniques based on
24 diagnosis.

25 DR. MYKLEBUST: Oh, I see.

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1 DR. KASS: Based on the diagnosis. "The" diagnosis.

2 DR. MYKLEBUST: Yes. Now, if you pull it back to

3 this (indicating), based on-- It will be based on 4, won't it?

4 DR. KASS: Yes.

5 DR. MYKLEBUST: See?

6 DR. KASS: Yes.

7 DR. MYKLEBUST: Is there a better way of stating

8 "based on the diagnosis"? Based on the evaluation procedures

9 of education and psychology? Are we redundant here?

10 I can live with this idea of just --

11 DR. KASS: We used the words "accepted diagnostic

12 procedures."

13 DR. MYKLEBUST: Yes, you have. That's right.

14 DR. KASS: So we are referring now to the --

15 DR. RIDGWAY: You could use that same phrase again

16 and say "based on the diagnostic procedures."

17 DR. KASS: On the diagnostic procedures.

18 DR. MYKLEBUST: Yes, you could, couldn't you?

19 DR. KASS: Refer it back.

20 MISS TAYLOR: Would you read that sentence again?

21 DR. KASS: Remediation means that these deficits can

22 be corrected by educational techniques based on the diagnostic

23 procedures.

24 DR. BLAIR: I like Jim's idea of using the term

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25 "amenable." It seems to me that we have to be a little less

1 than positive, because not all of these are predictably-- I
2 think hopefully 95 per cent are.
3 DR. KASS: All right.
4 DR. MYKLEBUST: Then what do we have?
5 DR. KASS: May be?
6 DR. BLAIR: I think "may be" is a little too negative.
7 DR. CHALFANT: The "corrected" may be a little bit
8 confident.
9 DR. KASS: Are amenable to correction?
10 DR. BLAIR: If you say "amenable," you are at least
11 leaving the door open for failure in some cases.
12 DR. CHALFANT: Would you read that again, please?
13 DR. KASS: Remediation means that these deficits are
14 amenable to correction -- "through" I guess -- through edu-
15 cational techniques based on the diagnostic procedures.
16 DR. MYKLEBUST: Now we are coming I think.
17 DR. HEWETT: Are we talking about sentence 6, or is
18 that going to come in --
19 DR. KASS: Yes.
20 DR. MYKLEBUST: That will be No. 6, yes.
21 DR. KASS: No. 6.
22 DR. MYKLEBUST: Now, Phil?
23 DR. HATLEN: How about "remediation means the cor-
24 rection of"? Because I think you are giving a verb definition

25 for a noun. "It means that these." It was "to remediate."

1 Then it would be --

2 DR. MYKLEBUST: Again, Phil, please.

3 DR. HATLEN: Remediation means-- Well, read yours

4 again.

5 DR. KASS: Remediation means that these deficits are

6 amenable-- Yes, means amenability to correction.

7 DR. MYKLEBUST: That's too awkward.

8 DR. CHALFANT: Yes.

9 DR. KASS: The term "remediation" means that-- We

10 could do that.

11 MISS TAYLOR: "Indicates" might do it.

12 DR. CHALFANT: Treatment.

13 DR. MYKLEBUST: "Treatment" is very troublesome.

14 DR. KASS: The term "remediation" means these de-

15 ficits are amenable to correction.

16 MISS TAYLOR: Instead of "means" could you say

17 "indicates"?

18 DR. HATLEN: All right. That would be okay.

19 MISS TAYLOR: Then you can --

20 DR. HATLEN: It's not defining a specific --

21 DR. SELZNICK: Remediation means the application of

22 educational techniques.

23 DR. HEWETT: Couldn't you solve this by putting

24 "amenable" in that first? Learning process is amenable to

25 remediation through special educational techniques.

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DR. MYKLEBUST: If you leave out the term "requiring," you would have no criterion stated. It's the term "requiring" that puts a limit on how many you are going to get in there or who is going to get in there.

DR. RIDGWAY: Maybe the fact that the word "remediation" is underlined and sort of in quotes here solves our problem, because this makes it a noun in this sense, but it doesn't change the structure of the word.

DR. MYKLEBUST: You can say the term "remediation" refers to, and so on, if you want to I think. But let's have it now the way Corrine has it.

DR. KASS: The term "remediation" indicates that these deficits are amenable to correction through educational techniques based on the diagnostic procedures.

DR. MYKLEBUST: How does that sound to you?

DR. HEWETT: Would you say "the" or just "based on diagnostic"?

DR. KASS: I said "the" in order to refer back to --

DR. HEWETT: To be specific?

DR. KASS: Yes.

DR. WOLFE: I don't like "based on diagnostic procedures." It sort of hangs. It doesn't do much.

Read the last half of that again.

DR. KASS: Educational techniques based on the diagnostic procedures.

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1 DR. CHALFANT: I keep wanting to move "based on diag-
2 nostic procedures" right after "remediation," but it makes it
3 hard to define it that way. Or "remedial techniques based on
4 diagnostic procedures." That doesn't fit the sentence.
5 DR. MYKLEBUST: No.
6 Bill, there is a little redundancy here anyway, so
7 would you prefer "based on" --
8 DR. WOLFE: I'm thinking --
9 DR. MYKLEBUST: -- "evaluation procedures in educa-
10 tion and psychology"?
11 DR. WOLFE: I would prefer "as determined" by some-
12 thing, rather than "based on."
13 DR. SELZNICK: Let me throw out another one. Remedia-
14 tion means the application of educational techniques based on
15 diagnostic procedure for amelioration.
16 MISS TAYLOR: Oh, I think that's complicated.
17 DR. SELZNICK: Okay. Forget it.
18 DR. HEWETT: That's a three-dollar word -- "ameliora-
19 tion."
20 DR. RIDGWAY: Read the first part again.
21 DR. SELZNICK: Remediation means the application of
22 educational techniques based on diagnostic procedures.
23 DR. BLAIR: Not bad.
24 DR. HEWETT: Special educational techniques do you
25 think?

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1 DR. BLAIR: Well, we have got that above.

2 DR. HEWETT: We might as well go all the way redund-
3 ant.

4 DR. MYKLEBUST: Now, Harrie, do you have that re-
5 vision, and shall we hear it again? I need to hear it again.

6 DR. SELZNICK: Remediation means the application of
7 educational techniques based on diagnostic procedures.

8 DR. MYKLEBUST: Frank suggested "special."

9 DR. SELZNICK: All right. Remediation means the
10 application of special educational techniques based on diag-
11 nostic procedure.

12 DR. KASS: As determined by?

13 DR. DENO: That doesn't say anything you haven't al-
14 ready said in the first sentence.

15 DR. WOLFE: It doesn't tell me anything new, what
16 you have said there, that we haven't said up here.

17 DR. HEWETT: It's that "requiring remediation" we
18 were trying to soften.

19 DR. DENO: You know, you're right. The point we
20 were trying to make was that it required special educational
21 techniques, so maybe it should read that way -- requiring
22 special educational techniques for their remediation.

23 DR. KASS: We have already said that. It seems to
24 me all we are defining is the word "remediation."

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25 DR. HEWETT: Remediation means you have done the job

1 though. If you require the special techniques to do the job,
2 isn't it clear? If you say "requires remediation," it means
3 you have got to be successful, whereas if you say it requires
4 the special techniques if you're going to do the job --
5 DR. SELZNICK: Change the word "means" to "requires."
6 Remediation requires the application of special educational
7 techniques bazed on --
8 DR. RIDGWAY: You can take care of that by changing
9 sentence No. 1 -- requiring special educational techniques for
10 remediation.
11 DR. HEWETT: In other words, remediation means you
12 have done the job.
13 DR.RIDGWAY: You won't need sentence 6.
14 DR. MYKLEBUST: Why not try that? If that will do
15 it, it's a very great saving. Did you get it, Corrine?
16 Requiring special educational techniques for remediation.
17 DR. HEWETT: Then the onus is on the techniques, not
18 saying for sure the remediation is going to take place.
19 DR. KASS: Then we still must define "remediation."
20 (General dissent.)
21 DR. MYKLEBUST: I think not now, Corrine, but we will
22 all have a second take on it. We could still use a sentence
23 on remediation if we think it's necessary.
24 MISS TAYLOR: I don't think so.

25 DR. KASS: I think tying the techniques to the

1 diagnostic procedures or the remediation to the diagnostic
2 procedures is a rather smart thing to do.
3 DR. BLAIR: Maybe that is assumed.
4 DR. KASS: Do you want to assume?
5 DR. MYKLEBUST: I don't mean to sound pontifical at
6 all, but it seems to me that in this sort of thing if you do
7 add the sentence on remediation you are taking it a little out
8 of the doubt even though you have done this at the first. The
9 first sentence is better I think. And I think if you put this
10 sentence on we still have the advantage of having said some-
11 thing about remediation.
12 So shall we go ahead with it and see if we can do it?
13 Or do you think now-- Are we doing too much over again?
14 DR. HEWETT: I can't help but say it involves applica-
15 tion of special educational techniques. You're just going to
16 turn the sentence around really, aren't you?
17 DR. MYKLEBUST: No, --
18 DR. DENO: You're not defining the disability anymore
19 when you get into that.
20 DR. BLAIR: I think there is something to be said for
21 the phrase "amenable to correction" which was eliminated in the
22 revision of that last sentence.
23 DR. MYKLEBUST: Yes, and there is something to be
24 said for Corrine's point too that if you tie it to basic
25 diagnostic procedures in a real professional sense-- Let's say

we are not trying to go out and make trouble here, but it seems to me that we have reason to also assume and state that we don't just look at these children and put him in.

DR. DENO: What if you said a learning disability refers to one or more significant deficits in essential learning processes which are amenable to correction through special educational techniques?

DR. BLAIR: That's Proustian.

DR. RIDGWAY: It gets us back into the other problem.

DR. BLAIR: I think reiteration has some value.

DR. MYKLEBUST: Bob?

DR. RIDGWAY: I can see two things here. One, if we define remediation we are not really defining a learning disability. Remediation is an understood term to most of us, so that we are getting here into what you do with such a youngster.

But, on the other hand, I think I heard you saying there are people who are dealing with children with learning disabilities in ways that are not related to specific diagnoses.

DR. MYKLEBUST: That's right.

DR. RIDGWAY: -- and that we at least make a statement --

DR. MYKLEBUST: That's right.

DR. RIDGWAY: -- sort of repudiating these people if we stick in something about remediation.

DR. MYKLEBUST: That's right.

1 DR. RIDGWAY: So even though it is not related to the
2 definition, it might be wise to do it.
3 DR. MYKLEBUST: I think that's right.
4 Jim?
5 DR. CHALFANT: I keep thinking of Corrine's point
6 here. I'm not sure if this fits. Deficits are to be defined
7 in terms of accepted diagnostic procedures in education and
8 psychology which lead to educational planning.
9 DR. DENO: What if you said deficits are to be de-
10 fined and education planned in terms of accepted diagnostic pro-
11 cedures in education and psychology?
12 DR. CHALFANT: Corrine wants to link the remediation
13 as being based on the diagnosis.
14 DR. HEWETT: Why not put it in the first sentence --
15 which are based on? Special techniques for remediation which
16 are based on diagnostic procedures.
17 DR. KASS: The whole point for these additional
18 sentences is to --
19 MISS TAYLOR: To clarify.
20 DR. KASS: -- have the first sentence the essential
21 part of the definition, be very simply stated, and then to
22 define whatever terms are not understandable within that state-
23 ment.
24 In other words, what we usually get into are a lot
25 of qualifying phrases and clauses following difficult words.

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1 What we propose to do here is to take these words out of a
2 simple definition and clarify it.
3 DR. HEWETT: Why not take "special educational tech-
4 niques for remediation" out then and define that in terms of
5 diagnostic procedures? You have taken out "deficits" and
6 "essential learning processes." You could take special educa-
7 tional techniques for remediation refers to diagnostic -- are
8 based on diagnostic assessment procedures or something.
9 DR. KASS: Yes.
10 DR. HEWETT: That would really link it, make it all
11 solid. You have almost every word defined in the first sentence.
12 DR. MYKLEBUST: Here's a comment also of merit. Let's
13 look at it. Frank suggests that we take that phrase, "special
14 educational techniques for remediation" and then "refers to,"
15 et cetera, whatever we are going to say, as a sixth sentence.
16 I would like to see that worked through if we may and
17 see how it comes out.
18 So, Corrine, how does yours end there? Do you want
19 to see how it comes out, please?
20 DR. KASS: Starting with "special educational tech-
21 niques"?
22 DR. MYKLEBUST: Yes, "special educational techniques
23 for remediation means."
24 DR. KASS: That deficits are amenable to correction --
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25 DR. MYKLEBUST: "The" deficits.

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1 DR. KASS: That the deficits are amenable to correction through educational techniques as determined by the diagnostic procedures.

DR. MYKLEBUST: Frank, we run into using "educational techniques" twice in the same sentence.

DR. HEWETT: Special educational techniques for remediation are based on. What are they? They are determined by or are based on diagnostic procedures or diagnostic --

DR. KASS: All right.

DR. HEWETT: Are determined by or --

DR. MYKLEBUST: Are determined by accepted-- No, we said that.

DR. HEWETT: Arrived at or --

DR. WOLFE: Related to.

DR. HEWETT: It's awfully neat that way then. That whole first sentence comes alive without a lot of --

DR. KASS: Special educational techniques for remediation are determined by the diagnostic procedures.

DR. HEWETT: That would come after your deficits, wouldn't it? We already talked about accepted diagnostic procedures.

DR. MYKLEBUST: It will be No. 6. It will come after No. 5.

DR. RIDGWAY: No. 6 will have four underlined words, won't it?

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1 DR. RIDGWAY: "Special educational techniques for
2 remediation" is the term we are defining here.
3 DR. MYKLEBUST: Now, it seems to me we are up to this
4 last two or three words that Bill is having trouble with, and
5 I'm having a little trouble with them. They are based on or
6 determined by what?
7 DR. KASS: The diagnostic procedures.
8 DR. MYKLEBUST: Determined by?
9 DR. HEWETT: "In education and psychology" is what
10 you will have said before.
11 DR. MYKLEBUST: You will have said that. All right.
12 DR. HEWETT: That's right.
13 DR. MYKLEBUST: Bill, okay? Do you still have trouble
14 with it?
15 DR. WOLFE: Yes. Let me read something here. Having
16 it as it is right now plus the definition of the word "remedi-
17 ation" as No. 6, let me try this on you:
18 "Remediation refers to the alleviation of a problem
19 through the use of specific techniques related to acceptable
20 diagnostic procedures."
21 This is true of the word "remediation" whether it
22 is learning disorders or cerebral palsy.
23 DR. BLAIR: It's a little redundant in terms of
24 sentence No. 4, using that phrase "accepted."

25 DR. SELZNICK: That is the one word that bothers me

most.

DR. WOLFE: I was using it intentionally here but related to the-- No --

DR. MYKLEBUST: All right, Phil.

DR. HATLEN: Is it techniques for remediation "determined by" the diagnostic procedure or the "result of" diagnostic procedure? Because you don't have anything to work from from the diagnostic procedure. From the results of the diagnosis.

DR. WOLFE: That's the thing that bothered me originally.

MISS TAYLOR: Diagnostic findings.

DR. KASS: Let me just throw this out. I don't know. So often we hear the professional diagnostician, the person talking about the diagnosis being "ongoing" and that we interpret a test and we try remedial procedures. But the remedial procedures in themselves be a diagnostic procedure and so on.

I should just like to make a case for the diagnostic procedure being just that as determining --

DR. HATLEN: Does that mean the same thing as "diagnostic procedures" in sentence 4 then?

DR. MYKLEBUST: Yes. Exactly.

DR. KASS: Yes.

DR. MYKLEBUST: Now, just a minute.

MISS TAYLOR: "Process" I would think.

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1 DR. MYKLEBUST: You were ready, Jim?

2 DR. CHALFANT: Well, the thing is that the diagnostic
3 procedures lead to the remedial techniques. Now, I think Cor-
4 rine's last statement I would agree with. I'm not sure of your
5 connection.

6 DR. KASS: I think the meaning is the same as saying
7 "are determined by the diagnostic procedures," with "pro-
8 cedures" being used in the generic term of the whole gamut of
9 test interpretations.

10 DR. WOLFE: You are not saying, are you, Corrine,
11 that what you do with this child is dependent upon what was done
12 in the diagnostic workup?

13 DR. KASS: Yes. Yes, I am.

14 DR. WOLFE: Or is it not determined by what is found
15 as a result of these procedures? You see, the procedures them-
16 selves cannot or should not, as far as I'm concerned, deter-
17 mine how you work with this kid -- the procedures per se. What
18 you find by using these procedures, yes.

19 DR. KASS: Well, except that as a clinician my pro-
20 cedures would be dictated to a large extent upon some initial
21 hypothesis. In other words, --

22 DR. MYKLEBUST: Well, Corrine, --

23 DR. RIDGWAY: You are getting at the clinical teacher
24 notion here.

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25 DR. KASS: I guess so.

1 DR. MYKLEBUST: If I see the point here, "procedures"
2 is giving us a little bind. Now is "findings" then a better
3 term? Diagnostic findings?
4 DR. HEWETT: I think that's what you have got after
5 you have done the procedures, after they have been undertaken.
6 DR. MYKLEBUST: Corrine, how does that sound to you?
7 Does it sound right?
8 DR. KASS: It's all right. I think we are still with
9 in the problem we have of the clinical psychologist, the school
10 psychologist, who defines the problem, diagnoses the problem,
11 and we don't get beyond that point unless we are involved in
12 a procedure. I'm sorry. I can't get away from that.
13 DR. SELZNICK: You are saying in essence that the
14 diagnostic procedures will give direction to the process of re-
15 mediation?
16 DR. KASS: Yes.
17 DR. MYKLEBUST: Yes, but we have to say it a little
18 easier, you see, Harrie.
19 DR. KASS: Yes.
20 DR. MYKLEBUST: Now, "are determined by the diag-
21 nostic findings" Corrine feels is limiting.
22 DR. WOLFE: Ongoing diagnostic findings?
23 DR. MYKLEBUST: Well, now, we are in real trouble
24 I think if we are going to say it is all ongoing.

25 MISS TAYLOR: How would it be if you said "directed

by the diagnostic procedures"? That assumes that it is on-going since it keeps directing remediation.

DR. KASS: I'm convinced that the procedure itself does dictate. The tests we use. It may be wrong, but it --

DR. MYKLEBUST: All right.

DR. RIDGWAY: Maybe the hangup here is that there are perhaps two stages of this. At one time you did some diagnostic work and used the findings in the way that Bill is suggesting. And then you determine what you are going to do. From then on you are doing some diagnostic teaching.

DR. WOLFE: I'll buy that.

DR. KASS: Okay.

DR. RIDGWAY: From that point you are doing what you are suggesting.

DR. HEWETT: One is educational; one is psychologica

DR. MYKLEBUST: Can anyone help us get this stated here?

DR. DENO: The point that we are trying to make, as I understood it, is that we are dealing with a type of disability, a deficit which we consider to be amenable to reduction if the appropriate corrective procedures are applied.

DR. WOLFE: But not diagnostic procedures. Remedial procedures.

DR. DENO: Right. So what if we say something like the term "remediable" implies that the deficit is considered

1 amenable to reduction when appropriate special corrective pro-
2 cedures are applied?
3 DR. KASS: This isn't referring back to diagnosis.
4 DR. DENO: But that is what is appropriate. How do
5 you determine what is appropriate?
6 DR. MYKLEBUST: That's going to give us difficulty.
7 Every time you use qualifiers like that, you're in trouble.
8 Immediately you ask for argument with "appropriate" and so on.
9 Couldn't we simplify that, Evelyn, and get this into
10 more straightforward language like the sentences we have up
11 here?
12 DR. ASHCROFT: Couldn't we just say "procedures and
13 results"? Wouldn't that handle it? Diagnostic procedures and
14 results?
15 DR. MYKLEBUST: And findings?
16 DR. ASHCROFT: Or "and findings."
17 DR. HATLEN: Now, if No. 4 is an attempt to delineat
18 or to set up some standards, then diagnostic procedures may h
19 a little different connotation, and maybe it is diagnostic
20 findings there. But diagnostic procedures would fit in the
21 other sentence about remediation.
22 DR. MYKLEBUST: I don't see how you can use "find-
23 ings" in No. 4, because these are the procedures, the scien-
24 tific procedures, evolved in the basic science manner from
25 education and psychology.

1 DR. FLIEGLER: On one hand, if I might interrupt for
2 a moment, Phil, we are talking about deficits. On the other
3 hand, we are talking about teaching strategies in remediation.
4 And although these are related, they are not the same thing.
5 And I think this is what is hanging us up if I go back to your
6 original statement, Bob.
7 DR. MYKLEBUST: But, Lou, we have now a revision.
8 Could we hear it, please? Could we hear the revision, Corrine?
9 DR. KASS: Special educational techniques for remedi-
10 ation are determined by diagnostic procedures and findings.
11 DR. BLAIR: Corrine, I wonder if I could just build
12 on yours. I don't know if the term "clinical" is negative,
13 but --
14 DR. MYKLEBUST: For what, Frank?
15 DR. BLAIR: Well, if we add to Corrine's the phrase
16 "are determined by clinical and educational diagnostic pro-
17 cedures," then it seems to me we are implying both initial
18 evaluation plus ongoing possibly.
19 DR. MYKLEBUST: Bob?
20 DR. RIDGWAY: I was thinking of something like this:
21 Special educational techniques for remediation require educa-
22 tional planning based on the diagnostic procedures and results.
23 DR. WOLFE: That's closer.
24 DR. KASS: Okay.
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25 DR. SELZNICK: Yes.

1 DR. MYKLEBUST: Once more, Bob.

2 DR. RIDGWAY: Special educational techniques for re-
3 mediation require educational planning based on the diagnostic
4 procedures and results -- or "and findings." Either one.

5 DR. HEWETT: Would "based on" be better than "required"

6 DR. RIDGWAY: I said "required planning based on."

7 DR. HEWETT: I see.

8 DR. RIDGWAY: You're right. We did use "require" in
9 the first sentence so this probably should be changed.

10 DR. MYKLEBUST: Now, if we are getting a breakthrough
11 here-- Let's see. Corrine has been up writing a lot. Who
12 would write this up for us? Lou, would you write No. 6 up for
13 us as read so we can take it from there?

14 DR. FLIEGLER: I'd be delighted. This is No. 6 did
15 we say?

16 DR. MYKLEBUST: Yes.

17 DR. FLIEGLER: Try me again, Bob.

18 DR. RIDGWAY: We haven't really talked about whether --

19 DR. MYKLEBUST: I think if we can get it up here on
20 the board we can see the redundancies and so on.

21 DR. RIDGWAY: Special educational techniques for
22 remediation require educational planning based on the diagnostic
23 procedures -- and either "results" or "findings," whichever
24 seems best. And your comment there is a much better one than
25 the "require."

1 DR. BLAIR: If you leave out the article "the," you
2 are less apt to be pointing to initial diagnostic procedures.
3 DR. MYKLEBUST: We have another change suggested here.
4 Could we start from the beginning? Corrine, you have a change
5 starting where?
6 DR. KASS: Special educational techniques for remedi-
7 ation refer to educational planning based on.
8 DR. RIDGWAY: Good.
9 DR. MYKLEBUST: I think the "referred to"-- Corrine
10 makes a real point. It goes back to the sentence above. Okay?
11 DR. WOLFE: Yes.
12 DR. MYKLEBUST: All right. It refers to, meaning
13 what we have said before. Refer to educational planning based
14 on diagnostic procedures and results. You can't say on findings,
15 diagnostic procedures and findings. Well, actually, that isn't
16 grammatically correct. You have to say some kind of results
17 there, don't you? It's grammatical, isn't it? All right?
18 DR. KASS: And results.
19 DR. MYKLEBUST: Now, you have then a complete state-
20 ment up here in No. 6. How does this sound?
21 DR. ASHCROFT: How about putting the results before
22 the procedures? Diagnostic results and procedures.
23 DR. BLAIR: They don't come in that order.
24 DR. WOLFE: They don't come that way.
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25 MISS TAYLOR: Doesn't procedures also involve the

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1 results?

2 DR. ASHCROFT: That's right.

3 DR. MYKLEBUST: Well, Corrine has talked to that

4 point here.

5 DR. HEWETT: "Evaluation" takes care of both, doesn't

6 it?

7 DR. MYKLEBUST: Well, not in Corrine's opinion. She

8 has been stating this here as being something involved in this

9 process. And, of course, as I understand Corrine's point, it

10 means that -- if I could give an example, Corrine; I hope it

11 fits -- if someone gives a Bender, they are looking at the

12 procedure as such in terms of implications for remediation and

13 so on. Here you can't do it without the procedure as such.

14 It's an active observation it seems to me. And you observe

15 perseverative aspects and so on.

16 It seems to me that is what you are saying.

17 DR. KASS: And the choice of the Bender itself is

18 part of the procedure.

19 DR. MYKLEBUST: So I suppose you can-- Well, I mean

20 Corrine does make a point here that it isn't necessarily the

21 same. Now, I wonder when we put "procedures and results" here

22 whether we don't now have all that we need in it and spell it

23 out. It's pretty clear, it seems, isn't it?

24 DR. DENO: Is that special educational techniques,

25 sentence 6, supposed to discriminate between regular and

special educational techniques? Is that the intent of it?

DR. KASS: Yes.

DR. DENO: But the fact that it is based on diagnostic procedures and results does not discriminate between regular and special education, does it?

DR. MYKLEBUST: No, you could do that in regular too. Oh, yes, you could. It wasn't I don't think intended to, but it is intended to tie it to objective professional diagnostic effort.

Jim?

DR. CHALFANT: I'm having a little bit of trouble here. Special educational techniques for remediation refers to educational planning. That doesn't quite fit. Perhaps I'm not thinking about this properly. Doesn't "techniques" refer to "instructional methods"?

I mean the "refers to" changes the educational planning from "requires." I could accept that, but the "refers to"-- "Techniques" does not refer to educational planning. It refers to instructional methods which are based on your diagnostic procedures.

DR. MYKLEBUST: Well, do you --

DR. WOLFE: Methods.

DR. MYKLEBUST: Let's see if we have this here. Refers to educational -- other than "planning" now. You don't want "methods," do you? I'm asking. I think that's loaded for

1 trouble.

2 If we could use another term it might be easier. But

3 what would you use in place of "planning," Jim?

4 DR. CHALFANT: Programming.

5 DR. MYKLEBUST: Programming? Refer to educational

6 programs? Okay? Do you want to try that? No?

7 Frank?

8 DR. HEWETT: It's just that techniques don't "refer

9 to." They are "developed from" or they are "derived from."

10 Or you could "come up with them from."

11 DR. KASS: We are talking about the term, yes. This

12 must be underlined. "The term" is understood in front of this

13 sentence, you know.

14 DR. HEWETT: But it's the subject of the whole

15 darned thing.

16 DR. KASS: This is the subject of the whole thing.

17 Actually the subject is "the term." And then this apposition --

18 "refers to." Or "the phrase refers to." Shall we say "the

19 phrase refers to"?

20 DR. MYKLEBUST: No, we didn't in the others. I think

21 it is well understood there using underlining.

22 DR. RIDGWAY: It should be "refers."

23 DR. MYKLEBUST: Yes, you're right. That has been

24 troubling me. Refers to.

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25 DR. KASS: Yes, you're right.

1 MISS TAYLOR: I have a trouble that I just can't keep
2 quiet about anymore. That is the very first sentence where we
3 say a learning disability refers to one or more significant
4 deficits. I think we either have to put "learning disability"
5 in quotes or say "the term 'a learning disability'" or say
6 "a learning disability involves one or more."

7 DR. WOLFE: That's right.

8 MISS TAYLOR: It has been bothering me right along.

9 DR. RIDGWAY: It's a child.

10 DR. HEWETT: A child with a learning disability has.

11 DR. MYKLEBUST: The committee went through that very
12 carefully. You get into lots of difficulty in writing this if
13 you talk about the child. Here you are talking about the prob-
14 lem and learning and not the child per se.

15 But down below you use "children." You say children
16 with learning disability generally demonstrate, and so on.

17 But there are pros and cons. It started out here
18 this evening with the child that came out this way. Do the
19 rest of you find trouble with "a learning disability refers
20 to"?

21 DR. RIDGWAY: What would happen to the meaning if
22 the first article were taken out as she suggested?

23 DR. ASHCROFT: And say "learning disabilities refer"

24 DR. MYKLEBUST: Yes.

25 DR. RIDGWAY: Just one. "Learning disability refers

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1 to."

2 DR. MYKLEBUST: Now, that, Sam, is another problem.

3 A great many people have questioned the use of plurals here all

4 the time. That came up in the committee hearing. And there

5 is reason for using this in the singular. Today the science

6 writers and others are getting away from the plural.

7 Now, do you like "learning disability"? How about

8 that, Committee? Any comments?

9 I think it helps it to take out "A."

10 Thank you, Jo. "Learning disability refers to."

11 That does it, doesn't it, Jo?

12 MISS TAYLOR: That relieves my anxiety.

13 DR. HEWETT: At this point what about "significant"?

14 We refer to deficits down below. Do we have to qualify what a

15 "significant deficit" is?

16 In other words, we use that term, and then we only

17 refer to "deficits" down below. What means that it is sig-

18 nificant?

19 DR. MYKLEBUST: Well, how would you feel about

20 leaving the word out entirely and not going on with explaining?

21 DR. HEWETT: If you put it in you almost have to.

22 Where does "just plain old" leave off and "significant" begin?

23 DR. MYKLEBUST: I know. This is always difficult

24 when you get into these qualifiers. It really is.

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25 DR. BLAIR: It would seem to me it suggests an

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1 important problem. And we did go through this in the Committee
2 as to whether or not we should expand on this term, getting
3 into some kind of more precise measure. But I would feel that
4 the term "significant" lends --
5 DR. MYKLEBUST: But it does leave it open to question.
6 What do you mean by "significant"? Because you are saying the
7 extent of it is already covered in the last sentence -- or I
8 mean in the last part of the sentence.
9 DR. DENO: In the last part of the sentence really.
10 DR. MYKLEBUST: The "significant" in the last part
11 of the sentence tends to be redundant. We are saying that
12 these have the impact -- that is, that they are of sufficient
13 consequence to require special education.
14 DR. DENO: That's the whole point.
15 DR. MYKLEBUST: Yes. And I don't think "significant"
16 -- I'm just giving myopinion -- really adds. I think it might
17 cause more difficulty.
18 And when you start getting into defining "signifi-
19 cant" here, as Frank has indicated, it is going to be trouble-
20 some. How are you going to define it? What do you mean?
21 DR. HEWETT: You could just put it down in front of
22 the "deficits" in No. 4. You could say significant deficits
23 are to be defined in terms of accepted diagnostic procedures.
24 DR. MYKLEBUST: I can see that a lot more.
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25 DR. HEWETT: That takes care of it to some degree.

1 Then you can let your diagnostic procedure determine what is
2 significant or not.
3 But by itself up there it is kind of left hanging.
4 If you are going to leave it, it might be better to put it down
5 there.
6 DR. MYKLEBUST: Significant deficits? Okay.
7 DR. RIDGWAY: Did the Committee talk about the term
8 that has been used sometimes -- "educationally significant -- "
9 Was this discussed at all?
10 DR. MYKLEBUST: No, it wasn't, I don't think, Bob.
11 Now, let's note sentence 1 with "significant" out
12 and see if that is the way we want it.
13 Sentence 1: Learning disability refers to one or
14 more deficits in essential learning processes requiring special
15 educational techniques for remediation.
16 Bob, what is the trouble?
17 DR. RIDGWAY: I like it better the way we did it by
18 putting "significant" in front of No. 4.
19 DR. MYKLEBUST: That is what I did. I left it out.
20 Did I read it in? Didn't I leave it out? I want to leave it
21 out of No. 1, Bob, and I was reading sentence No. 1.
22 DR. RIDGWAY: I thought the suggestion was to leave
23 it in both and make it part of the term in No. 4.
24 DR. MYKLEBUST: Excuse me. I'm really slow. Is
25 that what you are talking about?

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DR. HEWETT: Either that or take it out. I thought maybe it could be either. If you leave it in, it should be in both places.

DR. MYKLEBUST: Sorry, folks. I see the point now. All right. And then put it in both places?

DR. HEWETT: If you are going to do it.

DR. MYKLEBUST: That's fine. Very good. Fine.

MISS TAYLOR: I'm bothered by that "define in terms of" -- that word "define."

DR. MYKLEBUST: Now, Jo, they did sweat over that word. They went through that new Dictionary -- that big. (Laughter)

What's wrong with it?

MISS TAYLOR: I think it is really the significance of the deficits is determined by these things.

DR. KASS: May I make a point about leaving it in? Because this is our first definition. Isn't this where we begin to-- Yes, we begin to define terms from the first sentence. So that we almost have to indicate that we are defining.

MISS TAYLOR: I think maybe if we just leave out the "to be" it might work.

DR. MYKLEBUST: Yes -- "are defined."

DR. KASS: To be or not to be. (Laughter)

DR. MYKLEBUST: All right. Fine. Significant

1 deficits are defined. I like it. That's good.

2 Now where are we? What else?

3 DR. HELLER: Just a matter of wording, but there in

4 No. 5 --

5 DR. MYKLEBUST: Now, Bill, just a matter of wording?

6 (Laughter) What have we been on the last hour? Go ahead.

7 (Laughter)

8 DR. HELLER: This doesn't bear on the content because

9 you could leave the word out. "Those currently most commonly

10 . . ." That's awfully awkward.

11 DR. KASS: Yes.

12 DR. MYKLEBUST: All right. Leave out "currently"?

13 DR. HATLEN: How about "most currently" and leave

14 out "commonly"?

15 DR. KASS: We could leave out "most commonly." Say

16 "currently referred to."

17 DR. MYKLEBUST: How about that? Leave out "most

18 commonly," Bill? Okay?

19 DR. KASS: It means this could change as new knowledge

20 is obtained about the human being.

21 DR. MYKLEBUST: Yes. I think that's fine. Anyone

22 else?

23 DR. HEWETT: This is silly, but essential learning

24 processes are those currently referred to in behavioral science

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25 "as perception" or those currently referred to in behavioral

science "as involving perception"? Can you have processes just referred to as perception? And integration? But does a process "involve" perception?

DR. KASS: Process is perception.

DR. HEWETT: Can a process be referred to as perception?

DR. MYKLEBUST: "As involving" is Frank's question -- as involving perception, integration. He wants to put in the word "involving" in front of "perception."

Okay? Involving perception, integration, and expression, either verbal or nonverbal.

DR. HEWETT: Will the English I-A seminar please come to order? (Laughter) We're going to diagram sentences after this is over. (Laughter)

DR. MYKLEBUST: I think it helps it.

Anything else?

(No response.)

All right. Do we all have this down? I think it will be there in the morning. But I repeat that starting at eight o'clock in the morning I will not be able to have this down for you, so you had better make copies here.

Now, if I get a copy myself I will see that copies are mailed to you after we get it typed up, and so on.

If we could go on, there is another question we should like to raise that shouldn't take very long, and this

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1 is beyond this definition. But with this definition in mind
2 there is need on the part of many people -- I'm not talking for
3 Corrine at the Office of Education or any other group or indi-
4 vidual -- but there is very real need for clarification regard-
5 ing incidence.

6 Claims are prolific today. And before we leave learn-
7 ing disabilities as the major problem for consideration and go
8 on to the multiply-handicapped tomorrow morning, I would like
9 to ask you whether it is agreeable, whether it is possible for
10 us to agree on a statement concerning -- what is it called? --
11 an informed estimate as to how many children we are concerned
12 with as people in special education and as people who must
13 help standards and guidelines for teacher needs, for diagnostic
14 center needs, for training grants for students, and so on.

15 I think if I may I won't go further into the back-
16 ground for the need for such a statement. Obviously I am just
17 asking you whether you feel we can make such a statement.

18 If we do, obviously, it will become a part of our
19 record of this meeting -- that it is our considered opinion
20 that the incidence of learning disability in a regular school
21 population is so and so.

22 Now, some of the estimates that you hear today are
23 way down there, 1 per cent, 2 per cent. And, of course, as
24 you know, they go up to 15 per cent on the part of a number
25 of people.

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1 In the material that I sent to you, I gave you a
2 couple of statistical findings on incidence, and these very
3 specifically refer only to this study and the way it was done.
4 Now, any statement of incidence as determined by a
5 study refers only to that study, because it depends on the
6 criteria we have established for it.
7 Now, if you use cutoff points, learning quotients,
8 establishing average and up intelligence, et cetera, and you
9 measure and define verbal and nonverbal problems by screening
10 and followup test procedures, then you find that the under-
11 achievers, the under-achievers by our criteria-- I'm giving
12 this now only as background, not as a statement of what we
13 should do. But the under-achievers as determined by our batte
14 of screening tests and the criteria that we use for cutoffs--
15 Then 15 per cent of a school population are under-achieving,
16 and I'm talking about school populations where there is a lot
17 of opportunity for instruction.
18 Of these, something less than half, like 40 per cent
19 of this group, turn out to have what we would refer to as
20 learning disabilities.
21 Now, if you reduce this in another way and ask what
22 percentage of the total population screened, then we come up
23 with 4 per cent.
24 But now I am not down at the level that Harrie was

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25 describing this afternoon -- that severe. We are including

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1 more than that.

2 Now, I hope these comments are helpful. I want to
3 get to the question and not just talk about this in this sense,
4 because I want you to just decide and do what you feel we should
5 do.

6 Do you feel that we can as a Conference Committee
7 give an indication of the incidence of learning disability in
8 a school population on a normative school basis? I'm not
9 talking about then, of course, school populations that are
10 likely to have way above average, way below average facilities,
11 opportunities, and children, and so on, but average, normative.

12 Would someone care to comment? Frank?

13 DR. HEWETT: Where have these kids been lumped be-
14 fore? Have they been lumped with the emotionally disturbed
15 kids? Are they part of that? Some guy says there's 5 to 15
16 per cent emotionally disturbed, about 10 per cent in general,
17 and, you know, 5 per cent severe, and up to 15. Have these
18 kids do you suppose gotten included in that?

19 DR. DENO: Some have.

20 DR. MYKLEBUST: Some have.

21 DR. HEWETT: It might not be more than 5 per cent if
22 they were in there someplace.

23 DR. MYKLEBUST: Well, now, we were involved for
24 five years in studying segments of the Chicago Public School
25 system. This is a different system than the one I just

1 referred to that we are working in. And we investigated this.

2 We went into selected schools, controlled schools

3 socioeconomically, ethnically, and so on. We studied all of

4 the retarded, all of the speech handicapped, all of the reading

5 disability, all of the emotionally disturbed, all of the

6 reading-- There were five. No, and then we had a normal con-

7 trol group from the same schools.

8 Now, you will find some of these children in all of

9 these categories. So in a sense we are taking these children

10 out of other groups to some extent.

11 Now, some of them, Frank, are also in the regular

12 classroom.

13 DR. HEWETT: They would drift I could see from one

14 category to another.

15 DR. MYKLEBUST: That's right. Now, we studied 200

16 children of each type in these schools and compared them with

17 normal controls. And this is what we found.

18 Corrine, did you have something?

19 DR. KASS: Go ahead.

20 DR. MYKLEBUST: Now, Frank's question, of course,

21 one that is very important here, is that all of these children

22 are not new children in special education. They are just de-

23 fined differently. Some of them are new. You find them, and

24 they have never been discovered in this sense. That's true.

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25 But, of course, I would judge from what data we have

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1 probably half of them are somewhere in some other class.

2 DR. KASS: May I suggest something here?

3 DR. MYKLEBUST: Yes.

4 DR. KASS: As Dr. Myklebust just indicated, incidence

5 depends on the criteria. It depends on a given study, the way

6 in which the study was done. Obviously we can't come to any

7 sort of conclusion on these. But could we play a game here and

8 take this definition? Given this definition, could each of

9 you give an informed or educated guess? Is this fair?

10 DR. MYKLEBUST: Well, yes. Well, I like the question.

11 I just want to say that, if we can, I think it would be a help-

12 ful part of this record for purposes of people that want to

13 know what we think this definition implies.

14 DR. WOLFE: I don't think we should say one percentage.

15 DR. MYKLEBUST: No, a range.

16 DR. WOLFE: A range.

17 DR. MYKLEBUST: I was wondering if we could get a

18 range, Bill.

19 DR. WOLFE: I'm going to start out, to get something

20 on the table. 3 to 5 per cent.

21 DR. HEWETT: Very good.

22 DR. MYKLEBUST: Bill suggests a range of 3 to 5 per

23 cent.

24 DR. HEWETT: I vote for that.

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25 DR. MYKLEBUST: Frank agrees.

1 Harrie, you have questions?

2 DR. SELZNICK: I think the incidence is greater. I

3 think that's a very conservative estimate.

4 DR. WOLFE: Well, we have to be in terms of what we

5 got through saying.

6 DR. SELZNICK: I was looking at sentence No. 2 in

7 particular -- spoken, read, or written language, mathematics

8 and spatial orientation.

9 DR. WOLFE: With these controls built in though.

10 DR. HEWETT: Not sensory, emotional kind of retarded

11 sort of factors.

12 MISS TAYLOR: Are you speaking about the school popu-

13 lation or the school age population?

14 DR. MYKLEBUST: The total school age population.

15 MISS TAYLOR: Age?

16 DR. MYKLEBUST: Yes, the total school age. Through

17 high school is the way I was thinking of it. Because many of

18 these are undiscovered in high school.

19 MISS TAYLOR: Many of them may be sitting at home

20 and not in the school population.

21 DR. MYKLEBUST: That's true too.

22 Bob?

23 DR. RIDGWAY: We screened about 1,500 kindergarteners

24 three years ago, and we don't have the results yet, but in

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25 terms of the first part of the definition, a significant deficit

ERIC

1 in some areas, on our test battery we were getting 5 to 6 per
2 cent. But we are not certain whether those were deficits that
3 required remediation, and we won't be until the computer spits
4 back at us later this month.
5 But I would agree with Harrie there are more of these
6 youngsters than we have identified, because we haven't tapped
7 the arithmetic group or the group that can't read maps.
8 I mean they have problems with spatial orientation,
9 and lots of them don't come to our attention.
10 DR. BLAIR: I'd like to suggest 5 to 10 per cent for
11 whatever it's worth. I think this matter of the present now,
12 as Mike was saying, in other groups that we see, remedial
13 reading clinics and speech clinics, and so on-- There are
14 numbers of them there, as well as the undetected ones. I would
15 think minimally 5 per cent.
16 DR. MYKLEBUST: Jim?
17 DR. CHALFANT: I know one of the concerns of the Of-
18 fice is to hold the number down to a low percentage. If you --
19 DR. MYKLEBUST: The U.S. Office?
20 DR. CHALFANT: Yes. If you have a large range-- Like
21 in speech correction for example. The prevalence figures are
22 somewhat comparable. You see a great range. Then in terms
23 of those that would receive priority in treatment -- like it
24 may be as low as 2 or 3 per cent and as high as 10 in this case.

25 But in terms of immediate treatment, as you have done in your

1 district, it would be directed toward the lower incidence group
2 initially or the lower prevalence group.
3 Perhaps we could come up with a range and then break
4 this down in terms of severity.
5 DR. MYKLEBUST: Yes.
6 DR. CHALFANT: In terms of treatment.
7 DR. MYKLEBUST: You notice there has been a suggestion
8 of the speech handicap, the reading disability, and so on. Now,
9 of course, all reading disabilities are not necessarily in this
10 group. All speech handicapped children are not necessarily in
11 this group. I think this is important that we keep in mind
12 that we are not talking about all of them in these populations.
13 On the contrary, we are talking, according to the
14 survey we have on it, only of a small percentage of these in
15 each of these areas.
16 Articulation defects as such wouldn't come under the
17 definition as I understand it. Neither would stuttering.
18 Neither would cleft palate speech, their structural problems.
19 They are defined out.
20 Emotional reading disorders are not in, you see.
21 Now, I would assume that is what we all mean, because
22 that is what we have been talking about here, and I think it
23 is very apropos that they are not all in.
24 Well, we have suggestions now from 3 up to 10 per
25 cent. I think if we are going to-- I hate to give a value

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1 judgment here at this point. I'm fearful of 10 per cent myself.
2 I think it's troublesome to many people, and I don't think we
3 really have this kind of evidence.
4 Now, please don't think that we think we have any
5 final answers, but I suppose we have studied in this study more
6 intensively a larger population than has ever been studied. We
7 are up to 2,000 children. In another year we will have 3,000
8 children. And they are very carefully defined by age and so on.
9 We have many basic sciences looking at them and all
10 of this. And I really believe that some of this problem is
11 being unduly exaggerated. It's bad enough and troublesome
12 enough the way it is. It would seem to me that if we go over
13 5 per cent we must be defensive. I think so. I really do.
14 DR. WOLFE: I do too.
15 DR. SELZNICK: Well, if the statement then refers to
16 a conservative estimate on the basis --
17 DR. MYKLEBUST: Conservative estimate.
18 DR. SELZNICK: If we say 3 to 5 per cent, as was
19 originally stated, I don't think we will have to back down from
20 it.
21 DR. MYKLEBUST: Please don't go by what I say, be-
22 cause it is just my opinion, like any opinion.
23 DR. BLAIR: We are working in the dark, obviously.
24 DR. MYKLEBUST: Yes. But, you see, when you go by
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25 stringent criteria, Frank, and really hold it down, you come

1 up with about 4 per cent.

2 Now, you know that Denmark says 10 per cent of chil-
3 dren have congenital hereditary dyslexia. Well, you just have
4 to take such statements with a grain of salt. That's all. They
5 aren't there.

6 Don't forget MacDonald Critchley never studied dys-
7 lexia. This is where a lot of this came from, you know, includ-
8 ing Texas.

9 DR. WOLFE: He came down.

10 DR. MYKLEBUST: I was at his Institute in London for
11 a while, and I can assure you he is a great man. I am not try-
12 ing to detract from this man. But this is where a lot of this
13 10 per cent business in reading is coming from, simply quoting
14 Hermann in Copenhagen.

15 And, of course, everybody has to get Critchley today.
16 That's the only answer there is. There's nothing wrong with
17 having this gentleman. He's a great after-dinner speaker.
18 But I'm not going to take his word for how many dyslectics
19 there are. He really hasn't looked at it.

20 DR. BLAIR: We're not talking just about dyslectics
21 either.

22 DR. MYKLEBUST: No, but this is the one that gets
23 it way out of line. It's the reading group that really throws
24 it off.

25 DR. DENO: Every State now is having to submit such

1 estimates for its State planning purposes under Title VI. It's
2 right in the guidelines. And it is a requirement that you do so.
3 We had a task force on special learning disabilities
4 in Minnesota that tried to sit down and use the data that we
5 had that was rather firm of various kinds in Minnesota and
6 applied criteria which are pretty well in here. That is, we
7 were looking at functional disability which would require special
8 educational techniques --
9 DR. MYKLEBUST: Yes.
10 DR. DENO: -- and assuming from studies that have just
11 been done of populations placed in special classes for the re-
12 tarded in Minnesota that some of those youngsters should come
13 out of there and would be in this kind of program, which would
14 be more appropriate for them if this program existed, and so
15 on and so on, and that this program should serve as a place-
16 ment vehicle for some children who have vision defects and
17 hearing defects along with other kinds of things. And then
18 there are other supports to it.
19 And on this basis, with this kind of figure, we are
20 projecting on the basis of 5 per cent. And this is then with
21 the understanding that this may cause some reduction of the
22 number in classes for mentally retarded. There is trading of
23 horses here.
24 DR. MYKLEBUST: And emotionally disturbed, and so on
25 and so forth.

----

1 DR. DENO: Some children that have been called
2 emotionally disturbed who would be better managed this way.
3 DR. SELZNICK: What do you do about spatial orienta-
4 tion, Evelyn? I see so many people driving cars that really
5 ought to be screened out at some point, among other things.
6 DR. DENO: Well, I guess some of this boils down
7 again to whether or not they can get along in the kind of
8 society we have got.
9 DR. HELLER: At Asheville, you know, the National
10 Association of State Directors, the figure I heard most common-
11 ly there was 5 per cent. They were talking about it within
12 their own groups.
13 DR. CHALFANT: It seems like there is a consensus
14 on a 3 to 5 per cent figure. If we stated this as conserva-
15 tively estimated as 3 to 5 per cent, is this the kind of state-
16 ment that you would need?
17 DR. DENO: You might say a conservative working
18 premise at this point on the basis of the best information we
19 have is that it's 3 to 5 per cent.
20 DR. MYKLEBUST: Are we agreed on this? Frank, can you
21 accept it?
22 DR. BLAIR: Yes.
23 DR. MYKLEBUST: Frank Hewett?
24 DR. HEWETT: Yes.
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25 DR. MYKLEBUST: Do you accept this all right, Sam

Ashcroft?

DR. ASHCROFT: I'd rather not play the game.

DR. MYKLEBUST: Now, you can't do that. (Laughter)

DR. DENO: They'll either play with you or without you, Sam. (Laughter)

DR. ASHCROFT: You know, the next question is: How many teachers?

DR. MYKLEBUST: That's right.

DR. KASS: Yes.

DR. MYKLEBUST: That's exactly the game. You are playing the game.

DR. KASS: That's the point.

DR. ASHCROFT: I have no data, so I can't make an estimate.

DR. MYKLEBUST: Well, the suggestion is that we as a group, as a committee, state something like this: The implication of this definition of learning disability is that, conservatively estimated, there are from 3 to 5 per cent of the children in the general school age population that fall within this category.

Yes, Bob?

DR. RIDGWAY: Lest someone start adding up all the categories, would it be appropriate to add to the statement the fact that no doubt some of these children are now currently being served in other programs?

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1 DR. MYKLEBUST: Yes.

2 DR. WOLFE: I saw those added, by the way, one time.

3 DR. MYKLEBUST: Did you get over 100 per cent?

4 DR. WOLFE: 128 per cent, if you take the blind, the
5 deaf, the cerebral-palsied. These health agencies, you know,
6 use a pet figure.

7 DR. MYKLEBUST: That's the trouble with some of them.
8 The statistics really get weird.

9 DR. WOLFE: I think this is an excellent idea.

10 DR. MYKLEBUST: Yes. Now, the followup statement
11 would be along this line: That some of these children are now
12 classified --

13 DR. WOLFE: In other special areas, such as -- not
14 trying to define them all.

15 DR. MYKLEBUST: No. Are now classified in other
16 special areas or in other categories of handicapped children,
17 such as the deaf, mentally retarded, and emotionally disturbed.
18 Is that enough?

19 DR. KASS: Yes. I think it's a good qualifier so
20 people don't draw the wrong conclusions that we are going out
21 and finding now some 5 per cent new children.

22 So you see, Sam, we already whittled it down to half.

23 DR. ASHCROFT: Very good. You might whittle it
24 down to 5.5 per cent, and that will give it a little more
25 authenticity if you put a decimal in it. (Laughter)

ERIC

1 DR. FLIEGLER: May I ask you a question, Mike? In
2 the population you studied are you including private schools,
3 certain institutional settings?
4 DR. MYKLEBUST: No.
5 DR. FLIEGLER: Parochial schools?
6 DR. MYKLEBUST: No. The selected population within
7 the public school frame.
8 DR. FLIEGLER: I hope we leave it at 3 to 5, but I
9 would strongly urge that someone who has the facilities and the
10 talent to explore these other areas-- Because we are talking
11 about school age youngsters.
12 DR. MYKLEBUST: That's right.
13 DR. FLIEGLER: And my guess is that we may be close
14 to that 10 per cent. This is just a suggestion. But this is
15 the kind of study I hope the U.S. Office of Education does on
16 a nation-wide basis, because this would be most instructive for
17 all of us.
18 DR. MYKLEBUST: Are you making such a recommendation?
19 DR. FLIEGLER: I certainly am, sir.
20 DR. MYKLEBUST: Fine. Okay. Anything else?
21 DR. RIDGWAY: Off the record.
22 (Remarks off the record.)
23 DR. WOLFE: What is going to happen to this definition
24 now?
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25 DR. MYKLEBUST: Well, all of these discussions, as

1 you can see, are going to be available to us. And I can't
2 talk for Corrine and the Office of Education, but we couldn't
3 do this without their help. And I might ask Corrine now if
4 she has any further comment on this in terms of what she would
5 think would be useful in terms of distribution and so on.
6 Do you have any comments?
7 DR. KASS: I should like to have this group decide
8 after they see the transcript -- after you see the transcript,
9 to suggest what you would like done with it. Perhaps we can
10 excerpt some suggestions which we could then make official as
11 the statement or statements of this group.
12 And we can then present these to the administration
13 at the Office of Education and disseminate as widely as you like.
14 DR. WOLFE: I would hope it would get down to the
15 so-called grass roots.
16 DR. KASS: Yes.
17 DR. WOLFE: Certainly the State departments of educa-
18 tion at least.
19 DR. MYKLEBUST: Now, I like Corrine's suggestion, and,
20 of course, now is a good time. Tomorrow we were going to try
21 to summarize a little of this. But when we get through working
22 here, we won't be through. We'll have to have everyone's
23 approval of the statements here, everyone editing their
24 statements. And I should think that it is within the realm of
25 the decision of this group, which we will probably have to do

1 by mail, that some publication of this could be made in a
2 journal, a special educational journal, and so on. If we all
3 can agree on it, we publish it as a committee that was called
4 to do this. And this would be only if it further served the
5 purposes that we are setting out to serve.

6 DR. SELZNICK: Reference was made to ACLD and the at-
7 tendance.

8 DR. MYKLEBUST: Yes.

9 DR. SELZNICK: I think this is a group that ought to
10 have access to the definition in particular so that there is
11 communication with the action group outside the schools.

12 DR. MYKLEBUST: Yes. Now, I think we had thought of
13 groups too, Harrie. Now, there are a number of groups. ACLD
14 would be the top.

15 Now, I don't know the extent to which we could pos-
16 sibly get involved in CEC's consideration of having a Division
17 on Learning Disabilities now. I might tell you it occurred to
18 me a number of times today because I personally feel there are
19 some very real problems in it.

20 Let's see. I can't remember if any of you are on that
21 Advisory Council now. Jim is. You have been getting the
22 material.

23 DR. CHALFANT: Yes.

24 DR. MYKLEBUST: I have been receiving mine. You have
25 received some?

1 DR. KASS: Yes.

2 DR. MYKLEBUST: Well, if I may say so-- I don't know
3 what Jim and Corrine think about this, but my opinion is that
4 we are getting way off on a tangent where we will have a Divi-
5 sion which is "ad limbo," not in special education, not in regu-
6 lar education. As a matter of fact, that is precisely what it
7 states.

8 Now, so you see, it seems to me, that this effort here
9 might be highly useful in such organizational work too. Would
10 you agree with that, Corrine?

11 DR. KASS: Yes.

12 DR. MYKLEBUST: Any other comments?

13 DR. RIDGWAY: I can think of two other places that
14 this could be useful and could be distributed with the permis-
15 sion of this group. One of them is that at the CEC meeting
16 this year I am responsible for an hour on Saturday during the
17 day when we are discussing curriculum materials centers. I am
18 responsible for the group that will be talking about materials
19 for learning disabilities. This could certainly be distributed
20 there and made available to everyone who comes.

21 DR. MYKLEBUST: Good. What is the other one, Bob?

22 DR. RIDGWAY: I was going to ask Corrine's permission
23 to use this definition in the final report I am to write up
24 and send to the U.S. Office and it is to be published in
25 CEC later, the CEC Journal.

1 DR. WOLFE: There's another organization, Mike.
2 DR. RIDGWAY: We can get it into print quickly if we
3 agree on it.
4 DR. WOLFE: Another organization would be the Associa-
5 tion of State Directors of Special Education. The National
6 Society for Crippled Children. The United Cerebral Palsy.
7 National Association for Retarded Children. These are all
8 agencies that, if they can be sold on this thing, can really
9 get it down.
10 DR. MYKLEBUST: That's right.
11 DR. KASS: Yes.
12 DR. MYKLEBUST: Well, I'm sure you feel that you have
13 had a long day. We have an interesting day coming up tomorrow
14 too.
15 Dr. Kirk asked several days ago whether he could be
16 excused for tomorrow. We have asked Dr. Sam Ashcroft to join
17 us. And we will make a brief preliminary statement about the
18 tasks that we have tomorrow as we see it first in the morning,
19 and then we will go on to this problem of definition and clari-
20 fication of the area of multipy-handicapped children.
21 Any other comments tonight?
22 DR. FLIEGLER: I don't know if this is in our con-
23 sideration, Mike, but somewhere along the line in something like
24 this -- I don't know if this ought to be an organization -- we
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25 ought to include general educators.

1 DR. MYKLEBUST: For distribution, dissemination?

2 DR. FLIEGLER: For distribution, dissemination. ASCD.

3 DR. RIDGWAY: IRA.

4 DR. FLIEGLER: That's right. I think this might be

5 a feedback as to how these people view the process. I don't

6 know if this was included.

7 DR. MYKLEBUST: No, it wasn't.

8 I would like to say -- I think Corrine would agree --

9 when the times comes we will need all of these suggestions in

10 order to make this the most useful possible, the greatest pos-

11 sible usefulness. I think it's exactly the kind of discussion

12 we would like to have. And certainly there is every intention

13 to try to get it to these people in general education. It would

14 be very helpful.

15 Okay. Thanks a lot for today. See you in the morning.

16 (Whereupon, at 9:20 p.m., the meeting was recessed,

17 to be reconvened at 8:00 a.m., Wednesday, August 9, 1967.)

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Transcript of Proceedings

CONFERENCE

LEARNING DISABILITIES AND INTERRELATED HANDICAPS

Sponsored Collaboratively by
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U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

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1 **C O N F E R E N C E**

2 LEARNING DISABILITIES AND INTERRELATED HANDICAPS

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7
Parkes Hall
8 Northwestern University
Evanston, Illinois
9
Wednesday, August 9, 1967
10
The Conference was reconvened at 8:05 a.m., Dr. Helmer
11
R. Myklebust, Director, Institute for Language Disorders,
12
Northwestern University, Chairman, presiding.
13
PRESENT:
14
Dr. Helmer R. Myklebust (Chairman)
15 Dr. Corrine E. Kass
Dr. Samuel C. Ashcroft
16 Dr. Francis X. Blair
Dr. James C. Chalfant
17 Dr. Evelyn Deno
Dr. Louis A. Fliegler
18 Dr. Philip H. Hatlen
Dr. Harold Heller
19 Dr. Frank M. Hewett
Dr. Robert H. Ridgway
20 Dr. Harrie M. Selznick
Miss Josephine Taylor
21 Dr. William G. Wolfe

22

23

24

25

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P R O C E E D I N G S

DR. MYKLEBUST: Good morning again to all of you.

The problem we have this morning pertains to the multiply-handicapped child. I think we all feel that this youngster has presented real difficulties in diagnosis and classification in educational remediation over the years.

I feel that if it were not for the U. S. Office's emphasis on this problem we wouldn't be as far along as we are. So to some extent I think we owe our consideration and our progress in looking at this youngster a little more completely to the fact that the U. S. Office not only does consider this youngster but provides training grants for students who are interested in becoming trained in this area of multiple involvement.

Now, this morning we do not have what we tried to do yesterday -- some position papers about the problems first. I'm going to go ahead and just make a few comments about this area primarily in terms of what we might direct our attention to today. Then Corrine and Sam will come in with their remarks too.

I was impressed with the observation of an outsider, so to speak, Dr. Smigel, when he said that to get into, to be able to function in this area of multiple involvement -- I have his quote here -- "now you'll have to know more."

I suspect that that's a rather important kind of

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1 observation -- that a person who is going to deal with these
2 multiple involvements probably is going to have to know more.
3 I think this is apropos Corrine's question yesterday
4 of curricula, of how to train, how to get people trained for
5 these multiple problems.
6 I suspect we will find, despite the need to watch
7 overcommitting these people to long-term training programs, it
8 will be necessary to know more than if they were working in
9 one area alone.
10 Now, there are various ways to approach this, as you
11 all very well know.
12 I would like to, if I may, just take a brief moment
13 to talk about what might happen in the next decade in this
14 area of multiple involvement and thereby in the area of handi-
15 capped children.
16 The direction that it seems to me we will be going
17 is towards much more information per child. The information
18 that will be secured will I think include much of the type
19 that we get now, but there's going to be additional information.
20 I think this is because of the tremendous advance-
21 ments in biomedical engineering.
22 This I could illustrate this way: That at the present
23 time you could take a youngster and put him in a given situa-
24 tion in a laboratory and automatically record his brainwaves
25 while he's in the act of learning, learning auditorially,

learning tactilly, or learning coming in auditorially and going out visually, which, incidentally, we do routinely every day in the week in one of our laboratories now.

I make the statement that if you can measure blood-pressure, temperature, pulse rate, et cetera, on an astronaut millions of miles out in space, surely you can measure some of these things in a child in a laboratory.

So to some extent -- very slightly at this time -- we hope more -- NASA is helping us, the National Space Administration is helping us, with this. Because their need is for a circumstance where what they call group environment telemetering will be necessary.

If you ask them, "What do you mean by that?" they say, "Well, you're not going to the moon alone. There's going to be a group of people."

Now this is to say that we are at the present time experimenting with telemetering from children in a classroom while they are doing anything that you ask them to do in a classroom. And this is at this time off-the-skull recording, mostly brainwaves, but, of course, you can record motor movements like this. I will get to that in a moment.

But I feel that in the next decade -- I won't stay on this question; I think we all see what we mean here -- this is the direction I believe not only in our field of special education but it is quite obvious this is the way it

1 is going in many aspects of medicine.

2 And Dr. Smigel also emphasized, in pediatrics today
3 they assume they will put a child in a given laboratory situa-
4 tion where he becomes a part of the total circuitry and you
5 see what happens as all this goes through and is recorded after
6 the child is part of this and is used as one of the ways in
7 which this aspect of his behavior, work, whatever it is, is
8 automatically recorded.

9 Well, I don't assume that we can today say that we
10 can quantify exactly the extent of seeing, of hearing, of
11 motor impairment, of emotional disturbance. I do suggest that
12 the direction will be along this line and that it will be very
13 much more so within the next decade.

14 We have an electronic pencil on the drawing board
15 so that when the child is in the act of writing you can very
16 easily put his whole motor system in the act of writing direct-
17 ly -- feed the impulses directly into the computer. We do
18 that now off the tongue. And it is very easy to measure hear-
19 ing this way. I think it is the way hearing will be measured.
20 Vision is a little bit more difficult at this time.

21 But until we have these things more established, you
22 and I face a lot of problems.

23 I don't mean this as an answer to all of our problems.
24 You know that. But it is the direction. And I think much more

25 quantification of certain aspects of involvement of any kind

ERIC

1 is already here, and, of course, will increase greatly it seems
2 to me in the next ten years.
3 Now, we have before us, however, the question of how
4 we might now, next year, the year after, and so on, more readily
5 for the benefit of the child, with more accuracy, say that this
6 child must be classified as being both deaf and blind, or deaf
7 and motorically impaired, or emotionally disturbed and a
8 learning disability.
9 You notice that on the basis of our work yesterday,
10 learning disability is another type of handicap in addition to
11 the others. For this morning's consideration, then, it means
12 that we assume -- we know -- that there is a group that is deaf
13 without other involvements, blind and hard of hearing, another
14 category, partially sighted, emotionally disturbed, learning
15 disability, and mentally retarded.
16 Now, the task before us today is the question of how
17 to better, more effectively establish that this child has
18 involvements of one of these in addition to one or more of the
19 others. This is really the question here.
20 So a child is blind but he also has hearing loss.
21 A child has a hearing loss but he is also emotionally disturbed.
22 A child is emotionally disturbed but he is also retarded.
23 Now, I'm sure you see that in many ways-- I think of
24 two basic things which I have already mentioned I remind you.
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25 In our culture, in our circumstances, our situation in this

1 country right now, we are already, may I say, legally or other-
2 wise, allocating funds for people to train in these areas. We
3 assume they are there. And, secondly, there is the possibility
4 that, because of the changes perhaps more in medical practice,
5 medical science than anything else, but also I think in terms
6 of much greater attention to culturally deprived, and so on,
7 we are in position now to recognize that these groups without
8 other involvement, the five areas, are somewhat less in inci-
9 dence, with an increase of incidence of the "in-betweens," like
10 the deaf with other problems, the blind with other problems,
11 the emotionally disturbed with other problems.

12 This population it seems is either greater because
13 more of these children live, survive, or are found, or whatever
14 the reasons. The problem of this multiply-involved youngster
15 seems to be greater than ever before.

16 Now, I think then that's about all I care to say at
17 this time. We are attempting then today to see whether we
18 might come to some agreement as to how we might refer to this
19 let's say hearing impaired child, as an example, who has other
20 involvements.

21 Taking our note from this (indicating definition on
22 board), the way we proceeded with this definition, I call your
23 attention to the fact that that was at least part of what I
24 was trying to suggest in the materials I sent to you.

25 You notice under the deaf it simply says, and I am

1 simply illustrating here:

2 "The deaf are children of school age who because of

3 a profound degree of hearing loss are unable to learn by

4 ordinary instructional methods."

5 Now, that is along the line of this (indicating

6 definition).

7 Then there are variables, such as when the deafness

8 occurred, and the degree of it, and so on.

9 I do not think that we could possibly today take each

10 of these and try to come up with a definition of each of the

11 five groups or the four. We did this one yesterday. I would

12 hope that we could agree that some of the ways in which these

13 groups have been defined before, particularly the retarded and

14 perhaps the deaf and the blind -- that it wouldn't be necessary

15 for us to go back and spend let's say a few hours on this

16 question of the deaf -- who are they, the blind -- who are they.

17 No. You notice that I did make some assumption that

18 it would be necessary for us to think about that. That is the

19 reason I put these materials in. But, rather, how we might

20 come up with some statement, if not definition, of who the

21 child is now if he has both visual and auditory impairment.

22 Can we take a look at that a little later as one of

23 the basic issues that we have before us today?

24 I don't think we need to say anything about the need.

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25 The need is very great not only from the training standpoint,

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1 from the financing standpoint, the funding standpoint, but I
2 think from the standpoint of programs in schools. I think the
3 need is really quite obvious.
4 Now, Corrine, would you go ahead, please?
5 DR. KASS: I would like to talk about this from the
6 point of view of my office. I feel that my office is more or
7 less a coordinating one. Whenever two or more handicaps are
8 present, the program proposals must come to the office that is
9 known as Interrelated Areas.
10 But it certainly is necessary to use consultants, to
11 use experts from all of the fields concerned with the handicaps.
12 I think a lot of the difficulty that my panel and I
13 wen' through last December in talking about the proposals was
14 probably the term or the label of the office, and that is
15 "Interrelated Areas."
16 We spent a great deal of time worrying about the
17 interrelated concept and whether this was something different
18 than merely an additive sort of thing of handicaps. And I
19 don't think this was ever resolved.
20 It might be because "interrelated areas" is a mis-
21 nomer. Perhaps it should be called merely "multiple handicaps."
22 "Multiple handicaps" takes in a lot of handicaps, a
23 whole continuum of severity, all the way from the rather ob-
24 vious combination of handicaps to the less severe overlapping
25 areas that we talked about yesterday.

1 So a lot is included here. But whether we can talk
2 about interrelatedness I think is very puzzling. And I wonder
3 if you people would give this some thought and perhaps give me
4 some suggestions about this.
5 Maybe we are struggling with a concept here that is
6 just not there.
7 There are very few training programs being funded.
8 There are three in the area of the deaf blind. There may be
9 more existing. I know of only one more. There are probably
10 four training programs in the area of the deaf blind. We are
11 funding one in the area of the blind retarded and one I believe
12 in deaf retarded.
13 Usually the practicum facilities in these programs are
14 located at institutions. In one program the deaf blind will be
15 housed in the school for blind. And this varies.
16 In one of my visits at a university I was interested
17 in a project that was going on with the preschool deaf, with
18 parents and children. The question was raised while I was there
19 about what to do with a youngster, an infant,who was referred,
20 who was deaf blind. The people in this project were quite
21 concerned because their major focus was the deaf, and they
22 didn't know how they could handle the deaf blind.
23 So I think a very important issue is: Do the person-
24 nel in these programs need a lot more education, a lot more
25 training, or is there some other way of doing this?

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1 DR. MYKLEBUST: Corrine has focused this very well.
2 The terminology then becomes one of our concerns this morning,
3 the terminology that we want to use to refer to this group.
4 I don't know the origin of the term "interrelated"
5 at the Federal level. I certainly agree with Corrine that it
6 has caused a lot of difficulty.
7 I think some concern here -- rather, some attention
8 here -- from this group, from all of us, on this terminology
9 could be very helpful, perhaps a beginning point if you don't
10 mind.
11 Now, Sam, would you go ahead, please? Do you have
12 some comments to make here?
13 DR. ASHCROFT: I think the major reason for my being
14 here is so you wouldn't have to shift names today from yester-
15 day. We can go from Sam to Sam without any trouble. (Laughter)
16 In reflecting on this a little bit, I have thought
17 back to some work we did some years ago in trying to find out
18 the incidence and prevalence of children with multiple handi-
19 caps in the area of vision, and we tried to do a survey.
20 In trying to think of a way to define these children for
21 survey respondents, we came up with a rather simple-minded
22 definition, and I thought I might give you that, at least as
23 a point of departure.
24 We said multiple handicapped children are those having
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25 more than one handicap each of which in and of itself would

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1 require special education services.

2 Then, because we knew that there would be a lot of

3 difficulty in deciding who to report in such a survey, we

4 asked the respondent to describe the children rather than to

5 just enumerate them, to give us some descriptive phrases and

6 descriptive attributes of the children.

7 I don't think that worked very well, but at least

8 we did gather some data that showed at that time -- this was

9 back in the '50's -- that at least one in five children in both

10 local day and residential schools for visually handicapped

11 children had one or more handicaps in addition to a visual

12 handicap, and frequently there were two or three additional

13 handicaps.

14 Of course, speech problems were very prominent, pre-

15 valent, mental retardation, and a surprising incidence of one

16 or more additional handicaps.

17 We don't have good data about the incidence and

18 prevalence of this problem. One of the best studies I could

19 cite with respect to visually handicapped children would be

20 the Cruikshank and Trippe study of services for blind children

21 in New York State. About 1959 is the date. And they gathered

22 data on more than 2,700 children and found that at least a third

23 of them had one or more handicaps in addition to their visual

24 problem.

25 Just some observations beyond the problem of defining

1 and the incidence problem. I don't think we can put some amal-
2 gamation of two discrete training programs together and come
3 up with a meaningful training program for children with multiple
4 handicaps. I think we have to look at the educational provi-
5 sions that are made for these children, and again I go back to
6 that earlier survey.

7 We were astonished to learn that there were actually
8 more children, multiple handicapped children, being served in
9 local day school programs than there were in residential schools.
10 And I think that is a serious problem.

11 It seems to me the residential school is uniquely
12 suited to serve problems of multiply-handicapped children, and
13 one of the problems we face is getting the children who can
14 function in local day school programs out of residential schools
15 to make room for children who have very serious problems and
16 for which the residential school would seem to be a much more
17 appropriate kind of place.

18 I think that we are concerned in our local community
19 with multiple handicapped children, but we are anxious not to--
20 Well, we have talked about a special school for the handicapped
21 in the Nashville metropolitan area, and our Department has
22 taken the position handicapped children ought to be served in
23 their local schools wherever they can and not assembled in a
24 special school for the handicapped.

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25 But a special facility such as that should be

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available for unintegratable children, children who cannot function in their local schools.

So this would be the kind of criterion, a kind of criterion it seems to me of seriousness of the problem that might be of some help.

Those are some random thoughts I have on the matter.

DR. MYKLEBUST: Random or not, very helpful, Sam. Very helpful. I think very interesting.

You notice that now we have before us the possibility that we should first of all consider our terminology in terms of "interrelated" or "multiple handicap."

I notice that Sam in his definition uses the term "multiply-handicapped."

Now, if we agree on the terminology, I think that Sam has given us a good takeoff point after the terminology question. Let's try to define the multiply-handicapped. He has already done it for us here. We could just take this and discuss it and see how we feel about it.

If we can then get terminology for this area that seems more effective and a definition of the whole area, then we go on and see what we can do about breaking it down. Is that agreeable?

Okay?

Now, what do you think about Corrine's question in regard to terminology? Who wants to start off here? Have you

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1 had problems with "interrelated" as some of us have?

2 DR. BLAIR: It doesn't mean very much certainly. It

3 doesn't communicate I think to anybody what it means.

4 DR. DENO: I don't think anybody else uses it except

5 the U. S. Office of Education.

6 DR. BLAIR: You don't know who started it?

7 DR. MYKLEBUST: No, I don't.

8 DR. BLAIR: It doesn't matter I guess.

9 MISS TAYLOR: This --

10 DR. MYKLEBUST: You know, I also promised myself that

11 I would-- I hope we will all talk very freely, but it is a

12 little hard for our Stenotypist unless I pin you down to one

13 at a time.

14 What else here? Shall we go ahead on the question of

15 "interrelated"? Do you like the term "multiply-handicapped"?

16 Phil?

17 DR. HATLEN: Well, "interrelated" seems to me to

18 assume that you can take these children, specifically define

19 the individual handicaps, and put them together and have some-

20 thing. And you don't. These kids are different from the singu-

21 larly handicapped children. And it is not an interrelated area.

22 It is a new and different area.

23 I can't think of a better term than "multiply-

24 handicapped" or "multiple handicaps."

25 DR. BLAIR: It is "multiple" or "multiply"? Now, we

1 see either one of these, and I think maybe there should be
2 some consensus on this.
3 DR. ASHCROFT: You also see "multi."
4 DR. HATLEN: "Multi-" with a hyphen.
5 DR. BLAIR: Yes.
6 DR. SELZNICK: Even the term "multiple" or "multiply"
7 or whatever means practically nothing in and of itself, because
8 there are so many combinations. And if the term is to give
9 some direction to the pattern of service or to the kind of
10 training for personnel working with children with more than a
11 single-area deficit, I wonder if we might not at least look at
12 other possibilities.
13 People ask me, "Do you have classes for the multiply-
14 handicapped"? And I say, "We have children with several
15 handicaps, but I don't know what group you are talking about."
16 Individual youngsters require additional services be-
17 cause of particular circumstances present in the individual.
18 DR. ASHCROFT: Let me try an illustration for you,
19 Harrie. I don't think "deaf blind" is adequate for even the
20 group that have been classically defined in this way, because
21 they are not merely deaf and blind but are developmentally
22 retarded. Their communication problem is broad. They come
23 with a whole packet of problems. So I don't think the discrete
24 combination of two disabilities describes the situation.

25 So we can't go to "deaf behavior disorder children"

1 and those other kinds of combinations.

2 DR. SELZNICK: The impact of the several handicaps on
3 an individual will differ, and the services that an individual
4 with the same readings would require will vary from the one to
5 the other.

6 I think a term ought to give some direction. It
7 ought to tell you with whom you are working. It ought to give
8 you some idea as to the services that individual requires.
9 Otherwise it is just something for convenience.

10 DR. MYKLEBUST: Now, I think we are well under way
11 here. Let's go right ahead.

12 Frank?

13 DR. HEWETT: I was wondering. Historically, does the
14 multiple handicap refer more to the physically handicapped?
15 Has it been used more in terms of multiple physical handicaps?
16 That's always the impact. I hear about children being multiply-
17 handicapped, and I think of motor involvement and perhaps multi-
18 physical sort of problems.

19 I wonder if in a sense we don't leave out emphasis
20 or don't really include behavioral and learning disability.

21 DR. MYKLEBUST: I would certainly agree that it comes
22 from that orientation. It did originally refer to just the
23 physically handicapped without other problems.

24 DR. WOLFE: I'm having problems here this morning.

25 I might as well get them out here at the beginning. Because I'm

going to have great difficulty resolving these things.

I think I am being asked to accept the idea that there is such a thing as a child with "a problem," and I don't think I can recall ever having seen a child with just "a problem," particularly after you bring in the emotional aspects, the learning disabilities now.

I am having great difficulty finding where the handle is here.

Are you asking me to accept the fact that there is such a thing as a child with a single problem -- namely, one of these eight or nine that we enumerated yesterday? If so, I am having great difficulty accepting that.

DR. MYKLEBUST: Well, here is the assumption -- I speak for myself -- that I am making. And I do try to reflect it in these statements about these groups. That is this:

It is possible educationally in schools, in class-rooms, to handle some children with, for example, a hearing loss without worrying about their visual involvement, their mental retardation, or their emotional disturbance, and so on.

DR. WOLFE: No, I won't buy that last statement. I'll buy the first one.

DR. MYKLEBUST: Well, you aren't going to assume that you have to do more than what is average for a lot of these in terms of emotional? They're not emotionally disturbed. They don't need basic attention to this.

1 DR. WOLFE: Maybe my problem then rests with what we
2 do or what we seek.
3 DR. MYKLEBUST: It seems to me you are making an as-
4 sumption that everyone has to be handled as though they are
5 emotionally disturbed.
6 DR. WOLFE: No, but I say that most of these, quite
7 a few of these children are emotionally disturbed. We're going
8 to gear our program --
9 DR. MYKLEBUST: That's what we're saying. A lot of
10 them will need help for emotional problems. But I said there
11 is a group of children in each of these areas that you clas-
12 sify and handle in classrooms on the basis of an individual
13 involvement. Don't you?
14 DR. WOLFE: But should we?
15 DR. MYKLEBUST: Yes, of course. They don't need
16 great attention to all the other things.
17 DR. WOLFE: But some.
18 DR. MYKLEBUST: Yes. I said some don't need it.
19 Some do. The ones we are talking about here are the ones that
20 have something, as Sam says in his definition -- one or two
21 problems, each of which needs special education.
22 Well, that's all we said.
23 DR. HEWETT: What are the statistics? Is it about
24 a third of what you find that would meet your definition?

25 DR. WOLFE: I think it's higher.

1 DR. DENO: It's higher.

2 DR. ASHCROFT: I think it's growing. It is probably
3 well beyond that now.

4 DR. MYKLEBUST: Sam, could we clarify now? You were
5 quoting a study of the blind.

6 DR. ASHCROFT: Right.

7 DR. MYKLEBUST: So this pertains to blind children
8 with other involvements. Now, I have had a number of years of
9 work with deaf children with other involvements. At one time
10 I was full-time on this problem.

11 Now, today in schools for the deaf in this country,
12 in classes for the deaf, the estimate is at least one-fourth.
13 I am amazed at how close it comes to what Sam is talking about.
14 Frankly, I think one-third of the deaf children is a fairly
15 conservative estimate, because your rubella children also have
16 the CNS involvement. Your Rh children have CNS involvement.

17 In 1946 we published our first work on meningitis
18 deaf children. They almost invariably have other involvements
19 like brain damage -- meningitis and encephalitis being first
20 cousins and go together.

21 So today these children live. And they stay in the
22 schools.

23 So this group that doesn't have the additional
24 problem requiring special education is going down some
25 apparently, and the group that need it seem to be going up some.

1 Now, does someone want to comment about retarded? I
2 don't know what we think about that group today. How many of
3 those have --

4 DR. BLAIR: We did a study in Wisconsin on the deaf
5 which agrees with your figures. It came out to 25 per cent of
6 the 500 schoolchildren in Wisconsin we felt had other problems.

7 DR. DENO: Well, in our public school program for the
8 deaf I'll bet it's higher, because the school for the deaf is
9 taking in the children who fit what they do, and the public
10 school is having to accommodate to whatever is there.

11 DR. MYKLEBUST: That's right.

12 DR. DENO: And the State School for the Deaf takes
13 in children from areas where there is no public school program
14 available. So actually they are drawing in-- There are selec-
15 tive factors operating to give them a more favorable clientele
16 I think.

17 It seems to me as though we get into the same problem
18 no matter what group we talk about -- that how we address the
19 problem is determined by our systems of service and these kinds
20 of things and is not defined by the characteristics of the
21 children.

22 So when we talk about deaf children we are always
23 hopefully working with a mental health approach, so that
24 whether emotional problems are present or not our management
25 of the children reflects the fact that we are trying to maintain

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1 them in some kind of status.

2 I wondered in Sam's situation here where you were

3 developing a definition for this survey-- You must have dis-

4 cussed and made some decision about the fact that children

5 might have several kinds of characteristics which lend impedi-

6 ment to learning which if individually present might not require

7 special educational services but in their interactive effect

8 might add up to need for a special education service.

9 Your definition says that any one of them would re-

10 quire special education service.

11 DR. ASHCROFT: We didn't know how to handle that prob-

12 lem. But, of course, in the descriptive we got on children

13 this frequently occurred. They wouldn't have met traditional

14 criteria for, say, a hearing loss.

15 DR. DENO: Or a vision?

16 DR. MYKLEBUST: I think the point is very well taken.

17 This is true, isn't it, that --

18 DR. DENO: Yes.

19 DR. MYKLEBUST: -- it's the combination?

20 Bill, we'll be right back to your question. Bill has

21 raised a very basic question on assumptions which must be re-

22 solved for our discussions today. We will be back to it in

23 just a minute.

24 Go ahead, Jo.

25 MISS TAYLOR: I have nothing more to say. It was

1 already said.

2 DR. MYKLEBUST: All right. Then Jim.

3 DR. CHALFANT: I think this relates to your comment.
4 Some concern has come up over what to call the children, and it
5 is a question of "handicapped" being tied in with etiology.
6 We might follow the lead something like this -- of those chil-
7 dren which require more than one special educational service.

8 DR. MYKLEBUST: All right. Let's keep this in mind.
9 I'm going to ask us to again look at the question Bill has
10 raised, because it is a basic assumption in the discussion.

11 Go ahead, Bill.

12 DR. WOLFE: I would like to raise another one or point
13 out another feeling I have, Mike.

14 DR. MYKLEBUST: All right.

15 DR. WOLFE: If we do relate to this child as though
16 he had a single problem, is it not true that the longer we
17 relate to him in this way the greater the chance of him be-
18 coming multiply-involved?

19 MISS TAYLOR: Yes.

20 DR. WOLFE: Yes, I think so.

21 Now, if you say yes to this, you are going to get
22 yourself on my side on the first one, so I would suggest that
23 you weigh your answer. Because if we treat a child as having
24 problem A, and it is a single entity here, nothing else is

25 being done, the longer we allow him to live in this what I

1 would call somewhat sterile environment as far as his other
2 needs are concerned, he's going to feel the need for other
3 things.
4 I'm bringing in again the emotional bit.
5 DR. MYKLEBUST: Bill, --
6 DR. WOLFE: If we work with him say for four or five
7 years, it may be that he will now need the special education
8 services provided to the emotionally disturbed because of lack
9 of attention in the first few years.
10 DR. MYKLEBUST: Well, I'm not sure I follow, but it
11 seems to me the assumptions you are making here I wouldn't say
12 yes to at all.
13 In other words, I agree with Evelyn that you use the
14 mental health approach to all children and the same as any
15 other group of children.
16 MISS TAYLOR: That's part of the treatment of that
17 one.
18 DR. WOLFE: Should be. Let's be realistic.
19 DR. MYKLEBUST: You're not isolating him so that you
20 are making problems. I don't see the assumption at all.
21 Go ahead, Sam.
22 DR. ASHCROFT: I'm not sure I understand what you
23 mean, unless it is this: That the cliché in special education
24 has been that when you have a child with multiple problems

25 that you treat him in terms of the basic problem.

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1 Is that what you are talking about? Is that what
2 you mean by the single problem?
3 DR. DENO: Or the impairment.
4 DR. MYKLEBUST: He's talking about the five groups
5 here.
6 DR. WOLFE: I'm talking about the single problem that
7 I'm asked to accept. And I have difficulty accepting it. But
8 I will go along with what you are saying then. The same thing
9 is true here in what you are saying.
10 DR. MYKLEBUST: As I understand, now, to get this
11 straight here, Bill's feeling is that there is no such thing
12 as a hearing impaired or a visually impaired or a motorically
13 impaired child that should not be considered multiply-
14 handicapped.
15 DR. WOLFE: No, no, no. I wouldn't go that far.
16 DR. MYKLEBUST: That's the assumption you're making.
17 DR. WOLFE: No, no. I said --
18 DR. MYKLEBUST: Where do you cut off? Then there is
19 no disagreement.
20 DR. WOLFE: We don't have adequate statistics on this
21 is what I am saying. I think finding a child with "a problem"
22 would be rare. I'm not saying all. I wouldn't indeed ever
23 say that.
24 DR. MYKLEBUST: Well, we are not concerned about
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25 the actual statistics here this morning. Our concern is that

1 there is a group of children with a given handicap that are
2 classified and managed educationally according to the given
3 handicap.

4 DR. WOLFE: Right.

5 DR. MYKLEBUST: All right. Then the other assumption
6 is that there are those who have more than a given handicap and
7 must be handled and educated differently. They have different
8 personnel training problems for them, and so forth.

9 DR. HEWETT: Sam, were you referring to children who
10 had a defined primary handicap and some additional secondary
11 handicaps that happened to be troublesome enough so they would
12 also require special education? Or were you talking about a
13 kid with three or four primary kinds of handicaps? Are these
14 additional handicaps always secondary? Or can they all be of
15 equal --

16 DR. ASHCROFT: I think we have talked as if they were
17 secondary. We have frequently said, you know, if we had a
18 blind retarded child, that he is a blind retarded child, not
19 a retarded blind child, and, "Therefore, he's the responsibility
20 of people in mental retardation. We in the blind, you know,
21 can't dirty our hands with him because his more basic problem
22 is the retardation. If you can remedy that, then we will take
23 him back as a blind child and we can do something for him."

24 DR. SELZNICK: Look at the other side.

25 DR. ASHCROFT: Then the retarded people say, "He's

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1 not a blind retarded child. He's a retarded blind child, and
2 he's your responsibility. If you can handle the blindness, we
3 will take care of the retardation."
4 DR. HEWETT: So we have different kinds of problems
5 here. We may have across-the-board primary, and we may have
6 some secondaries and a couple of primaries, and we --
7 DR. ASHCROFT: That's why I don't think, you know,
8 trying to find "the" basic which is primary and which is
9 secondary-- I don't think that helps us at all.
10 DR. MYKLEBUST: Well, it may not. And, if possible,
11 then, we would not try to say what hierarchy of pecking order
12 we are going to insist on. It seems to me this must be left
13 to the school systems, to the programs in the States. But,
14 rather, that there are these children that need attention ir-
15 respective of what the hierarchy of involvement might mean.
16 DR. WOLFE: When you say leave it to the schools,
17 Mike, watch out. Because in our State we have the ridiculous
18 interpretation in our State guide which says that if a child
19 has multiple involvement, mental retardation being one of these,
20 then mental retardation will take precedence over all of the
21 others and he must be included in the mental retardation
22 program.
23 This is totally inadequate, ridiculous.
24 DR. MYKLEBUST: Well, I can certainly see it would

25 cause problems, Bill.

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1 Does anyone else have that?

2 Yes, Jim?

3 DR. CHALFANT: Well, I'm sorry. I --

4 DR. MYKLEBUST: I was just going to say now that

5 States will vary a great deal. I'm just expressing my opinion.

6 I certainly agree with Sam's comment that this is very diffi-

7 cult on a hierarchical basis. Though in this I do discuss some-

8 what the major handicap concept in the material I sent you. I

9 admit it. This is one of the ways it has been approached for

10 many years. I don't feel that it is critical, however, to the

11 concept of multiple involvement. Multiple involvement will

12 be variously interpreted then in different settings, and so on,

13 as to which is major and which is the basis for the major clas-

14 sification. I think they are fairly separate issues.

15 Jim?

16 DR. CHALFANT: Now, with respect to this multiple

17 involvement, which is another way to get around this handicap

18 problem, it seems there are two or three blocks here.

19 First, you get into combinations and permutations

20 when you deal with the etiological aspects, the kind of dis-

21 order.

22 And then the question was raised over here that some

23 of these things should not be etiologically described but they

24 are of sort of a functional nature.

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25 And, third, the question was raised of the problem of

1 providing services.

2 Now, one way to handle this might be to focus on the

3 service necessary for these involvements rather than on the

4 etiological disorder.

5 DR. MYKLEBUST: Now, you're not going to refer them

6 as visually impaired or retarded or anything, Jim. Is that

7 etiology here in this sense? I'm not sure what you mean.

8 DR. CHALFANT: I was thinking in terms of a definition,

9 if that's what we are still after.

10 DR. MYKLEBUST: Yes, Evelyn?

11 DR. DENO: I think what Jim is saying relates to the

12 same point that I am always uncomfortable about. I think we

13 use these terms which have just come to be handles on communica-

14 tion over the years, of hearing and vision and so on, as

15 though, you know, we are using them because the etiology is

16 the significant thing here, which I think maybe it is.

17 But when you are talking about the deaf and you are

18 talking about vision, and so on, you are really talking about

19 the modal cluster of services which has developed around some

20 needs of these children.

21 So when we say "deaf," we really mean children having

22 a modal cluster of needs. This is what we mean, but we kind

23 of short-hand and say "deaf children."

24 So this kind of fits in with what you are saying and

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25 may be why there are only three or four programs, because it's

1 the children who can't be served through these systems that
2 have ordinarily been developed around these modal needs. And
3 then we get into some special kinds of systems here which
4 require a complex of services which is very broad and inter-
5 disciplinary.

6 DR. MYKLEBUST: All right, Jo.

7 MISS TAYLOR: I think another situation here, which
8 is what I thought Mr. Wolfe was saying-- I think those of us
9 who work chiefly with one type of handicap, of which there are
10 only a few here, or one, whatever you want to call it, are
11 aware that there are many other children, let's say visually
12 handicapped, who have additional problems which may be rather
13 minor compared to the blindness but which if not given
14 attention will develop to a point where they really will need
15 more serious services.

16 So that programs and teacher training programs have
17 become aware of the fact that many of the teachers trained
18 let us say to work with visually handicapped children don't
19 know enough about other ways of treating other serious problems
20 such as learning disabilities and therefore are asking for
21 special training for this.

22 My question is whether this should be in a special
23 training program for a particular cluster of handicaps or
24 whether there is some better way of providing this.

25 DR. MYKLEBUST: Very helpful. You see, the question

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is then whether you really need the multiply-handicapped as something unique and different. And this is very apropos to this discussion.

I think some of us feel that you do, that you do need some way of approaching this.

I am still unclear about the etiology thing. If you mean you are going to handle deaf children, blind children, retarded children as a given entity, I think that is going to be extremely difficult. I think there must be consideration for the types of involvements we are talking about. After all, this is the way behavioral science works. It is the only way you have knowledge about anything.

It would seem to me you would have to have knowledge about hearing loss and its effect on the psychology of learning, visual impairment and its effect on the psychology of learning, brain damage, dysfunction of the brain, and its effect on the psychology of learning. I think this is where we could get together and have the psychologies of learning as we begin to see them in relation to given aspects of handicap, given involvements of the organism.

Now, Harrie, you have something?

DR. SELZNICK: I just wanted to get this out on the table. You know, a few years ago -- actually, over a number of years -- the Council for Exceptional Children had its special study on the preparation of professional personnel to work with

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1 exceptional children. That wasn't the exact title. And various
2 task forces each investigated the various categories to which
3 we had assigned youngsters.
4 Each came up with what it suggested as an appropriate
5 training sequence, various experiences and understandings to be
6 promoted, but at no point along the way was there cross-
7 fertilization and an effort to identify the areas of commonality
8 -- that is, what was basic to teaching children whether the
9 deficit be in one area or another.
10 And maybe this has a relationship to what we are
11 talking about now. And instead of trying to set up a new se-
12 quence, a different sequence, we ought to try to identify more
13 specifically what is common to the needs of children in whom
14 we find more than a single deficit and for whom services have
15 to be organized.
16 DR. BLAIR: I think it is a good point, Harrie. I
17 think all of this does relate to how we train teachers ulti-
18 mately, and I think the primary disability concept has some
19 validity in these terms.
20 At the same time, I think there is a need, as we
21 are trying to do in our department, to bring various exception-
22 alities together in terms of training. We are trying to set
23 up core courses. We have developed one in language development
24 for exceptional children, which we think will serve many areas,
25 you see, because language is certainly a common area of need

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here for all children.

I think as we think of the ultimate goal here -- that is the funding of training programs -- I think this primary disability thing may still have some real validity in those terms.

DR. MYKLEBUST: Okay. Are you ready to consider more specifically the question of whether we want to change terminology? We have been talking about concepts. Are we ready to look at what this concept we are talking about might be called or how we are going to identify it?

Bob?

DR. RIDGWAY: I twas just thinking that it seems to me that when we said we had programs for the blind, the deaf, or retarded, and so on, we were talking about programs for particular kinds of children. I believe the term "interrelated" has its greatest meaning when we think of it not as the children being interrelated but a program relating separate programs together, like deaf programs related to blind programs.

I mean this is the only way the thing makes sense to me, that this was the handle that the Federal Government put on this to have one category to talk about or one label for deaf blind, blind retarded, et cetera, to lump them all together like the other health impaired can mean so many different things.

But it was a term that was useful as a catch-all. And it seems to me that as I have listened here I have heard

1 people saying, "Don't try to get a single term like 'multiply-
2 handicapped' because this really doesn't mean anything." And
3 people have suggested that if you mean programs for deaf blind,
4 then say programs for deaf blind, or use terminology that helps
5 you determine what group you are talking about.

6 We know we have so few such programs that maybe for
7 Corrine's purpose we have to have a basket to put them in.

8 DR. MYKLEBUST: It would seem to me that is very
9 important also for the field -- that we have something to de-
10 signate this very obviously overlapping kind of problem.

11 Yes, Bill?

12 DR. WOLFE: I believe, Mike, we should look at the
13 term "interrelated" referring to the training program at the
14 college and university level and not out in a public school
15 setting.

16 We are working out there with the multiply involved,
17 but we are training our teachers through an interrelated pro-
18 gram.

19 Do you see what I'm trying to say here?

20 DR. SELZNICK: Yes.

21 DR. MYKLEBUST: Yes.

22 DR. WOLFE: Because, you see, in the setup in the
23 Office you are describing with this term, the kind of a train-
24 ing program which you would fund, those people who would come

25 from that kind of program then would go out to Baltimore and

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1 work with the multiply involved.

2 DR. SELZNICK: Good. Thank you. (Laughter)

3 DR. WOLFE: This is the way I see "interrelated."

4 DR. MYKLEBUST: We see your point. I'm having diffi-

5 culty though with we as a committee trying to come up with

6 terms for programs in universities.

7 First of all, it wasn't an assumption at all that we

8 would get into this. If we must, we must. But I don't think

9 it's going to work. I think this is quite a different kind

10 of task force or question.

11 I think that our problem is children. There are many

12 implications for training. I think all of the implications

13 for training are excellent, any of them that we can come up

14 with. It wasn't assumed that we were going to try to set up a

15 university training program to designate them by terms or any-

16 thing else. But it was assumed that we would like to have

17 better terminology, clarification of the groups of children

18 who need services from universities as well as anybody else,

19 everybody else.

20 In that sense, to try to designate "these are pro-

21 grams for universities" I think is very difficult.

22 I think there is an area here that we're overlooking

23 in a sense. That is, these children aren't being designated

24 today in a helpful manner. And, say what we will, what you

25 call them makes a difference. What you call these (indicating

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definition on blackboard) makes a difference.

Symbolic behavior in man being what it is, it's going to make a lot of difference to children.

If we call them "interrelated," there is one thing. I don't think it will move very far. I think the term has worn itself out.

I think "multiply-handicapped"-- I'm only trying to get us to move on if we are ready to. "Multiply-handicapped" does communicate to some people. I think it communicates very effectively to a lot of people.

Now, maybe we can come up with better terms. I don't think we can agree on the terms that you are going to call the deaf blind and all of the in-between groups. It seems to me now we have to have the profession of the blind, the profession of the deaf and others involved. We do cross over these things, but we're not going to be able to tell these groups at this time I don't think what they can do about this in the subcategory kind of classification nor the hierarchy.

I would like to see something that would be useful just as we have done here in a general way to designate a group of children that today it seems to me in a way are seriously in need of further designation, and that's the overlapping groups here. I think this is a question Corrine is raising.

Bill?

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1 DR. HELLER: Well, to me -- and, Corrine, correct me
2 if I am wrong -- "interrelated" as I see it in the Office was
3 a means of bringing in not only multiple handicaps but also
4 bringing together, for example, disadvantaged and MR. We ship
5 those to you as interrelated proposals.

6 Also it was a vehicle for bringing together programs
7 in regular elementary and secondary education in conjunction
8 with special education programs.

9 In other words, thinking of the philosophy that was
10 going on back in the Office at the time, this was a kind of
11 an intermarriage type of deal.

12 So "interrelated" here doesn't refer strictly to
13 multiply-handicapped things. It's a means to interrelate dif-
14 ferent types of educational programs, whether they be special
15 education or regular education.

16 DR. WOLFE: This is the point I was trying to make,
17 Mike.

18 DR. MYKLEBUST: Then you have a certain need for some-
19 thing there that is not what we are mainly concerned with.

20 DR. HELLER: Right. It doesn't communicate at all --
21 that term -- to what we want it to.

22 DR. MYKLEBUST: No. Any other comments here about
23 the terms?

24 Lou, go ahead.

25 DR. FLIEGLER: I'd like to ask Sam a question. He

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made a very telling point which makes a great deal of sense when we are talking about retarded disturbed kids or disturbed retarded kids.

You say these programs, talking about the blind and the deaf, you do not see as discrete programs, but as a new kind of combination. I wonder if you could explore that. Because, as Bill says, it is true we have been training our teachers of mental retardation and giving them a course in emotional disturbance, because most of the kids you find in a special class are emotionally disturbed.

To some degree we have been doing this in the area of the deaf.

And Sam has a new tack here that I think may not help our terminology but it certainly will guide us in the kind of directions we may want to go.

DR. ASHCROFT: I'd like to respond to that.

First, this may not be directly germane, but it is interesting to me to reflect on why these children became designated as deaf blind children rather than blind deaf children and why the programs for the blind happen to have these children when, gee whiz, you know, the language development problem for these kids is the really tough one.

And I like what Frank has suggested is going on in his program -- some core courses that cut across these areas. And language is certainly one of them.

1 And so we feel in our program preparation that
2 language development, language disorders and what we can do
3 about them, is a central part of the program preparation.
4 I would be willing to dispense with a lot of the stuff
5 we give routinely to teachers of visually handicapped children
6 in favor of emphasis on language disorders.
7 I would like to dispense with some of it in favor
8 of some help with behavior modification techniques, because I'd
9 like to see our kids have much more of that, and to heck with
10 the Braille. Anybody can help these kids acquire a reading
11 skill through Braille -- if we can get their behavior shaped
12 up a little bit so that they can relate to people and can, you
13 know, be a member of a group and that kind of thing.
14 Well, in our own program we have resorted to trying
15 to pull from all of these areas. We had an educational pro-
16 cedures course in each area, and we tried to pull components
17 out of those for an educational procedures in special education,
18 so we get rid of all the kids, deaf, blind, disturbed, retarded.
19 And they are getting the same song and dance in each.
20 DR. MYKLEBUST: May I respond to that just for a
21 moment? I think it is a very vital issue.
22 DR. FLIEGLER: Yes.
23 DR. MYKLEBUST: I agree entirely with what Sam says
24 and would be delighted with certain core approaches to training

25 of people in specialized areas.

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I would like to see some course work -- and we are going in this direction -- which considers the impact of a given involvement such as deafness and blindness on learning. So we are talking about the psychology of learning.

Of course, we have a course in the psychology of learning on the deaf, such as psychology of deafness, which is the way it impairs or affects learning. Now, if we then would say that if there is an impact on learning from a given involvement such as deafness, and if we say there is a shift in learning processes in the blind, it seems to me that the new area is how these interrelate.

The psychology of learning of the blind isn't necessarily directly related to the psychology of learning when you are both involved with hearing and visual impairments. But there is again a new psychology of learning.

This is essentially what we would feel would be new in kind of a combination of things.

To take it one step further, the kind of thing Frank is so heavily involved in-- I guess I said a little of this yesterday, didn't I? There may not be the same parallel to the psychology of learning in the emotionally disturbed. That I don't know. I just say that it is a little different kind of situation. Perhaps you are assuming something a little different here.

But I made the statement for one of these that a

1 70 or 80 IQ deaf boy, you see-- Let me put it like this: An
2 80 IQ deaf boy needs special education with a vengeance, where-
3 as an 80 IQ hearing boy might go in the slow learning classes
4 in the regular school system. But not when he is also deaf.

5 So it isn't just additive. Now you have a combination
6 which makes him a different individual and an individual for
7 whom special education is extremely important because he does
8 have potential for making out in life if it can be achieved.

9 So Evelyn Deno's comment I am very impressed with --
10 the fact that so many mildly hard of hearing children get to
11 special education but they have multiple involvement, don't
12 they, Evelyn?

13 DR. DENO: Sure.

14 DR. MYKLEBUST: They have other problems than the
15 hearing loss. Now, if it were only the hearing loss, they
16 wouldn't be with you, but they are in the programs for the hard
17 of hearing. They are there because they are identified with
18 the hearing loss or with the audiometer, and so on. But they
19 have a learning disability or they have emotional problems so
20 they are in the program for the hard of hearing.

21 DR. SELZNICK: May I make a comment about operations?

22 DR. MYKLEBUST: Sure.

23 DR. SELZNICK: You know, each of us speaks fromhis
24 own orientation and experience of course.

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25 DR. MYKLEBUST: Yes.

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1 DR. SELZNICK: I have classes for deaf retarded chil-
2 dren, or retarded deaf children -- I don't know what you call
3 them -- but it is basically a determination made on function,
4 observation and study.
5 Now, I have looked for personnel for these classes.
6 We have four such classes. And I have had teachers whose prim-
7 ary training was in the area of the deaf who have taken addi-
8 tional work in mental retardation. I have had teachers who
9 have come from the area and have been trained to be teachers
10 of the mentally retarded who have worked and who have been
11 given resource help and taken some training in education for
12 the deaf.
13 I don't know which is the better prepared person.
14 I think it's individual.
15 We have classes for orthopedically handicapped re-
16 tarded children. We have eight such classes. And it isn't
17 so much the orientation and the preparation as it is the
18 individual. Someone, someplace along the line, has given the
19 teacher sufficient understanding of children and growth
20 experience so that they have been able to perform satisfactorily
21 with children.
22 Now, I think school systems are going to continue
23 to staff-- Hopefully, the training centers are going to pro-
24 vide the broad background which will permit people to serve
25 children -- period -- rather than to serve diagnostic labels.

1 DR. MYKLEBUST: But you do assume that these people
2 achieve proper certification in given areas?
3 DR. SELZNICK: Yes, but that doesn't always insure
4 a thing. That doesn't insure much.
5 DR. MYKLEBUST: I didn't say it insured anything. It
6 makes it legal.
7 DR. SELZNICK: Or legitimate.
8 DR. MYKLEBUST: I'm saying we in training centers
9 can't avoid the fact that we must give them certification in
10 something.
11 DR. SELZNICK: Yes.
12 DR. MYKLEBUST: Otherwise you people can't hire them
13 legally, and you can't get reimbursement and so on.
14 So, of course, we have got to have enough of a program
15 ina given area so that we do this. At the present time it
16 seems to be just being practical about it, or you can't get
17 people into jobs.
18 Yes, Phil?
19 DR. HATLEN: Just to reiterate in a way what you
20 were saying, in the past year I have seen a lot of deaf blind
21 children and a lot of deaf blind preschoolers. I call them
22 deaf blind. They're really not. They are very multiply-
23 involved in addition to deafness and usually some visual loss
24 but certainly not blind.
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25 These kids don't fit into any cubbyhole. This is a

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1 different type child. I have taught blind children a long
2 time, and they are not blind kids.
3 And Miss Jackson, whom I have been working with on
4 this, is convinced they are not deaf children either.
5 We have, as I stated the other evening, some real
6 problems in a curriculum in this area for this coming year. We
7 think we are going to offer sort of a cross-section of courses
8 which we feel will be beneficial. But the courses which we
9 believe are going to be most helpful for the people whom we
10 will be training as teachers of deaf blind are the ones that
11 will be specifically in this area, and they'll be very much
12 internship type programs where they get out with children.
13 One of the things we want very much to do but we
14 don't feel we are going to have the time -- and this relates
15 a little bit to what you were saying -- is that we want these
16 people to get out and observe normal child growth and develop-
17 ment. We would like to put them in hospitals and observe what
18 normal infants do in development from very, very early infancy.
19 Because some of the rubella children that we have seen are
20 very grossly retarded developmentally.
21 It depends on time. We don't know what we are going
22 to be able to do in this respect. But is certainly a different
23 type child.
24 As far as certification is concerned, we went up
25 to Sacramento and talked at length with people in the

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1 credentialling office about a credential to teach deaf blind
2 children in California.
3 A bill was just recently passed in California making
4 it possible to have a restricted service credential, which
5 means-- Well, we have complicated credentialling procedures
6 anyway, but it means, in effect, that a person can receive a
7 credential, for example, to teach the deaf blind and not teach
8 in any other program in California.
9 We are not sure we want this, because we think we
10 are opening the door to any number of little tiny credentialling
11 programs of dual handicapping conditions.
12 And it seems to me that there is a core. There is
13 something basic to working with kids who are multiply-handicapped
14 that we don't have to become so definitive about the individual
15 types of handicaps. And yet they are different kinds of chil-
16 dren.
17 I don't know what the answer is. I don't know a
18 better term than "multiply-handicapped."
19 DR. MYKLEBUST: Frank?
20 DR. HEWETT: I think this all leads us to maybe re-
21 considering the point that Harrie made. What I think really
22 is needed in the field is not as much only focus on the five
23 or six or seven little circles that Sam drew with slight over-
24 lap but a great big circle into which all of these might be
25 placed and where the common kinds of deficits that keep these

1 youngsters from learning are spelled out, so that we deal
2 with them in frameworks that have applicability to the entire
3 group of handicapped children.

4 I think this is an important kind of thing to consider.
5 And something we have been trying to do is to think of emotion-
6 ally disturbed children as learning problems, retarded children
7 as learning problems, and attempt to define what is it that
8 they need to learn that we can do something about.

9 I think this will help us in dealing with multiply-
10 handicapped children, that we have a common denominator that
11 we can work toward with the whole group.

12 The sickest children I have seen are deaf-disturbed
13 children, or the reverse. The psychotic deaf child is the
14 most disturbed child we ever see in the hospital or I have
15 ever run across. They are different. And yet they are re-
16 lated. And I think we have to have common kinds of things that
17 we can work with.

18 DR. MYKLEBUST: Well, I think one way to view this dis-
19 cussion is that some of us look at this as generalists and some
20 of us look at it in other than generalist terms, more in terms
21 of a specific science and given involvements together with
22 other involvements, and so on.

23 We have been through this a lot in this State too
24 in recent years. A center that trains almost-- Well, it
25 trains a generalist to go out and do anything with handicapped

1 children. I think this goes much too far. I don't think this
2 person really-- As an individual, anyone might make it, Harrie,
3 but in terms of proper background of basic science and psychology
4 of learning in relation to given disabilities I think each of
5 these has a tremendous significance -- tremendous.
6 Just the effect of lack of sensory impact on the brain--
7 We are beginning to collect the brains of both deaf and blind.
8 We have already a neuropathologist working on it. And it is
9 very obvious that lack of stimulation in some areas of the brain
10 causes changes in the brain. It has been known in lower animals
11 for years. The old physician in London who did the post-
12 mortem on Laura Bridgman said so on Laura Bridgman. I quoted
13 his report. I looked it up and brought it into my discussion
14 of Laura Bridgman in my book, "The Psychology of Deafness."
15 There are fabulous neuropathological implications,
16 not just emotional, psychiatric, important and urgent as they
17 think they are. But there are many problems here. And I
18 think it depends on what we want.
19 Again I say we will have to go the direction the
20 Committee wants to go, but I didn't think we were going to
21 spend our day talking about how to train people to do this --
22 at least not until we have a little bit more idea of what
23 we are going to call the group or whether we agree that this
24 group is there, which is Bill's question.

25 And again I say if we agree they aren't there, if we

1 are going to treat them all as one big category, really today
2 is more or less out. We don't need today.
3 I'm trying to clarify where it seems to me we are.
4 With that, let's take a coffee break.
5 (Whereupon, a recess was taken.)
6 DR. MYKLEBUST: Now, may I call you to order again?
7 May I reflect that I think the discussion has been most exciting
8 and basic. Corrine and I were just comparing notes, and we
9 don't know of a session -- perhaps some of you do but we don't
10 -- that really concerned itself with the problem of the children
11 who have more than one handicap.
12 So I suppose we shouldn't assume that we are going
13 to be able to come up with a lot of answers today, but it is
14 very interesting that we might be plowing quite new ground.
15 And I say right now at this point that I hope that
16 sometime in the future we might have a session, perhaps at
17 one of your centers, where we would give consideration to this
18 problem alone, further consideration.
19 Obviously we are very much involved in it today in
20 this conference. I think discussion is going along extremely
21 well. Very basic issues are being raised, issues which cer-
22 tainly didn't occur to me. I think they are very important.
23 Several of you have made some observations now in
24 our little break that I thought we might start with.

25 Frank, do you care to make your observation here for

1 the group that I thought was very helpful, if we could start
2 off again with that?
3 DR. HEWETT: Regarding the learning disabilities?
4 DR. MYKLEBUST: Yes, and germane to this if you would.
5 DR. HEWETT: I think one of the most important things
6 that we accomplished with this learning disability definition
7 is the sort of preservation of an educational relevance. And
8 if there was any way to denote this or to sort of capture this
9 relevance in a phrase or description referring to a number of
10 disabilities, it would just be beautiful.
11 I just don't know how you can do this. This is the
12 thing. I don't know how you can do it without using a small
13 paragraph. But I think that was what was so significant about
14 yesterday's work. And it's too bad we couldn't aim for that
15 kind of relevance, educational operational relevance.
16 The "multiple handicap" is so cold and physical and
17 kind of removed. If there was some way to get this relevance
18 involved, I think it would be ideal.
19 DR. MYKLEBUST: I think the point is very well taken.
20 Corrine, do you want to read that for us and tell us what it
21 is, please?
22 DR. KASS: Here is a definition that someone slipped
23 to me. Children with multiple handicaps are those who require
24 a combination of special education services which takes into
25 account the particular handicapping conditions.

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DR. MYKLEBUST: Now, this is not to cut off discussion of anything, including more discussion of basic concept. But we did have this definition we wanted to call your attention to, in case we wanted to try to do what Frank is suggesting. I agree maybe we can't, but it certainly would be very interesting to try to do it in the next hour.

DR. BLAIR: I wonder if we could build on Sam's basic definition?

DR. MYKLEBUST: That's right.

DR. BLAIR: I have added just a bit to it. I haven't finished it. But the multiply-handicapped-- Maybe we should do what we did yesterday and not say "children with." But a multiple handicapped-- No, I'm not phrasing this properly.

Let me start off with Sam's exact wording.

The multiply-handicapped are those having more than one disability each of which would require special education. These conditions should be viewed in terms of the interactional effects on learning -- this is a term that someone else used -- rather than the additive effect let's say.

This is as far as I have gone with this.

DR. MYKLEBUST: Now, I think these suggestions are excellent. And along the line of this one, we are talking about those who are unable to learn by ordinary instructional methods. Then we get to this cold term that Frank talks of -- because of multiple involvement, and so on. If we could get

1 away from that-- But I suppose what we are all saying here
2 is these youngsters are not able to profit in the usual sense.
3 Sometimes you say "profit normally." I don't like this term
4 either.

5 But they can't profit by the ordinary instructional
6 methods, which is basic to this one, for these reasons. Now,
7 who wants to take it from there and see what-- I think it's
8 very interesting to explore for the next hour if we could. I
9 think it would be a very real contribution.

10 Go ahead, Corrine.

11 DR. KASS: One concept that has occurred to me has
12 to do with the special services, the fact that handicapped
13 children cannot profit from regular instruction. So one of our
14 key phrases is "requiring the special education techniques."

15 It seems to me that we are talking about something
16 even more than special education techniques in the traditional
17 sense, and we are talking about a sort of multi-special
18 education. It's still special education, I'm sure, but we
19 are talking about something a little more than over and above
20 regular education that is sort of one step removed.

21 DR. MYKLEBUST: Yes. And I think Frank has something
22 of that in what he has there -- the concept that we really
23 spelled out a number of things after we said it here. We could
24 do the same. As Frank too has indicated, you don't add these
25 up. It isn't part of any given regular program but something

1 different.

2 DR. KASS: Or not even a part of a regular special

3 education program.

4 DR. MYKLEBUST: Fine.

5 DR. ASHCROFT: Would you read the one you read again?

6 DR. KASS: Children with multiple handicaps are those

7 who require a combination of special education services which

8 takes into account the particular handicapping conditions.

9 DR. ASHCROFT: Frank's definition could be used as

10 some of these ways of defining terms. Maybe the interactional

11 idea could be used in defining, say, combination of special

12 education services.

13 DR. RIDGWAY: I like the point that was made earlier

14 that if you have a blind deaf child -- and maybe it was made

15 just in conversation at the break; I don't remember -- but if

16 you are going to teach him to read, you need to consider him

17 as a blind child, while if you are going to teach him to

18 communicate you can teach him as a deaf child, and that you

19 don't have anything that is primary here but you have to plan

20 a program that is based on the particular combination of

21 problems or deficits.

22 DR. DENO: But you can't teach him to read just as

23 a blind child either, because an ordinary blind child would

24 have a verbal symbol system already present which he calls

25 upon in the reading. So it becomes a recognition thing.

1 Whereas with the deaf it becomes a development of language
2 concepts along with the reading.
3 DR. ASHCROFT: Yes.
4 DR. RIDGWAY: It's not in the least simple, and I
5 didn't mean to infer that, but you have to change positions is
6 what I'm getting at. You can treat him as a special case of
7 a blind child one time, but you have to treat him as a special
8 case of a deaf child another time.
9 MISS TAYLOR: But actually it is even more than this,
10 because there is such a great degree of difference in hearing
11 loss among those called deaf blind today.
12 There are I think extremely few who are blind, edu-
13 cationally blind, but there is a great variation in the visual
14 loss.
15 So that even the method that you use in language
16 development, or when that has been acquired some teaching of
17 reading, varies from child to child to a great degree if you
18 take that particular group.
19 Am I correct in this from your experience at the
20 California school, for instance?
21 DR. HATLEN: Yes. This phrase "a combination of
22 special education services" has a connotation to me of a number
23 of specifically trained individuals working with a child. And
24 I felt we were getting more at an individual who has some
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25 background in a variety of areas that can work with these

1 kids.

2 I don't see it as a combination of services, at least

3 in this respect, talking about deaf blind kids.

4 DR. MYKLEBUST: Well, Phil, could we focus now on

5 not the person doing the work or not the individual variations

6 in the population, which are going to be and always are tre-

7 mendous, but rather on the population? Could we focus a little

8 bit on this question Frank has called to our attention here,

9 the population as a group?

10 Is there some way in which we might agree as to what

11 this group or how this group should be designated?

12 We all feel that the "interrelated" terminology leaves

13 much to be desired. It is, of course, one way of doing it.

14 It might work. But we think it isn't very helpful. I think

15 there is agreement about that.

16 We all have misgivings about the term "multiply-

17 handicapped," "multiple involvement." Phil says he can't think

18 of a better term. I think that it is true it was probably

19 first very much developed through the field of physical handi-

20 caps.

21 Do you want to consider just the term "multiple

22 handicap" for a little while and alternatives? How shall we

23 designate this population? I think it will have a lot to do

24 with how this group gets attention, this group of children,

25 including training programs.

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1 DR. DENO: Is it possible that we could do essentially
2 what we did yesterday? It seemed yesterday before we were
3 able to get together and put down a definition we came to a
4 consensus about certain parameters that we agreed on that were
5 limiting to the definition. And then we just got the words
6 to put into the definition to define those parameters.
7 DR. MYKLEBUST: Yes.
8 DR. DENO: That's essentially what we are doing here
9 when we are saying now or are establishing one parameter that
10 when multiple defects are present in a child these deviations
11 interact to affect learning and development in ways which are
12 unique to each case, and they are not additive, or something
13 like that, whatever you want to put in.
14 Well, are there some more that we could establish
15 that are important to a definition? And then this might lead
16 us to a term instead of starting with "multiply-handicapped."
17 DR. MYKLEBUST: All right. Interesting suggestion.
18 May I ask: Could we take this off the slate? I
19 asked the man to leave it on last night in case we needed it.
20 Do we need it anymore this morning?
21 (Erasing blackboard.)
22 Taking Evelyn's approach, let's see what we come up
23 with as parameters. What do we think this should cover?
24 Evelyn, will you take these one at a time and see
25 what we get before us? I think this explanation here would be

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1 very useful. If it comes up with something, fine. If we agree
2 that we want to leave it and come back to it some other time,
3 that's all right too.
4 Now, Evelyn, do you want to start us off?
5 DR. DENO: Well, these are the words I used, and I
6 already see troubles with the words, where other words might
7 be used.
8 But the idea was when multiple defects are present
9 in a child --
10 DR. FLIEGLER: Do you want me to write it out? I
11 thought you wanted parameters like you said yesterday?
12 DR. DENO: I don't know how to state it except in a
13 lot of words. I can't state it in one word. Maybe somebody
14 can think of it.
15 But when multiple defects are present in a child,
16 these deviations interact to affect learning and development
17 in ways which are unique to each case.
18 DR. MYKLEBUST: How about just "which are unique"?
19 DR. DENO: Yes.
20 DR. FLIEGLER: Did you say multiple "defects" or
21 "handicaps"?
22 DR. DENO: I said "defects," but if you use "handi-
23 caps," that implies you are already making a functional deter-
24 mination, which makes it a better word.
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25 Produces unique effect. And that's getting to the

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1 point that we don't think these things just add up.

2 DR. MYKLEBUST: On development and learning?

3 DR. DENO: Learning and development.

4 DR. MYKLEBUST: You want learning and development?

5 Excuse me.

6 DR. DENO: It doesn't make any difference.

7 DR. FLIEGLER: Guide me.

8 DR. DENO: Development and learning.

9 DR. FLIEGLER: (At the blackboard) Produces a unique

10 effect on development and learning.

11 DR. MYKLEBUST: Sam, you had something?

12 DR. ASHCROFT: I was going to suggest maybe "impair-

13 ments" for "defects." I don't know if that adds anything or

14 not.

15 DR. MYKLEBUST: Let's get all the terms up there.

16 DR. DENO: Yesterday we took "defects" out and put

17 the word "handicaps" in deliberately, because the word "handi-

18 caps" implies that a functional determination has been made

19 that this has a disabling effect. So it is a useful term for

20 that reason.

21 DR. MYKLEBUST: That's right.

22 DR. FLIEGLER: Do you want "handicaps" up there too?

23 DR. DENO: Yes. Because "defects" always bothers me,

24 you know. I think that all children vary in their learning

25 proclivities, and just because they learn better visually than

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they do auditorially, should you say it is an auditory defect?

DR. MYKLEBUST: Now, if you don't mind, I'll just call on individuals here that have been writing something.

Frank Blair, you have something?

DR. BLAIR: Well, I have just been trying to put this together. "Multiple handicap" refers to a condition of disability in which a combination of factors impede learning. This condition should be viewed in terms of the unique interactional effects of these factors on the process of learning. The educational requirements of children with multiple handicaps -- blank, blank, blank.

DR. MYKLEBUST: The parameter there would be --

DR. FLIEGLER: Special education techniques? Services? What's your preference?

DR. BLAIR: I think in view of what we were doing we would have to bring in special educational techniques required should reflect-- I think we want to reiterate the idea of interactional again, but I'm not sure how.

DR. HEWETT: Combination of special education techniques.

DR. DENO: Well, the unusualness of the special education techniques required will be conditioned by the deviation that is produced by these interactional effects.

DR. BLAIR: Not conditioned. Governed.

DR. DENO: In our original definition on learning

1 disabilities, a basic parameter in here was that these children
2 required special educational techniques which it was not feas-
3 ible to supply in the ordinary program of instruction. That was
4 a basic criterion in here.

5 It seems to me that in this one now we are getting to
6 a criterion within the special education organization that
7 these children -- that the interactive effect of their multiple
8 handicaps produces an accommodative need which is not possible
9 -- which is not feasible -- to achieve in the regular program
10 systems built around single disabilities.

11 That is the cutoff, but I don't know how you say that
12 in one word or two.

13 DR. MYKLEBUST: Yes. To start with, we won't try to,
14 Evelyn. Just so we get it down.

15 DR. FLIEGLER: Special education techniques required--
16 Beyond program systems?

17 DR. DENO: Beyond program systems which are satis-
18 factory for children with -- what?

19 DR. FLIEGLER: Which are satisfactory in special
20 education classrooms or --

21 DR. MYKLEBUST: Are present I think you mean. Which
22 are used now.

23 DR. DENO: As presently stated, or whatever.

24 DR. MYKLEBUST: Yes.

25 DR. DENO: We know what we mean.

1 DR. BLAIR: Currently exist.

2 DR. SELZNICK: Presently provided.

3 DR. FLIEGLER: For children with single disabilities?

4 DR. DENO: Around assumptions regarding single dis-
5 abilities.

6 DR. MYKLEBUST: Fine. Phil, go ahead.

7 DR. HATLEN: I would like to go back to Sam's defini-
8 tion, because I think there is a very important part of this
9 which we don't have so far, and that is that each of these in
10 and of itself requires, would require, special education tech-
11 niques.

12 We were talking about this this morning. You work
13 closely enough with exceptional children, with handicapped
14 children, and you can identify multiple handicaps in all of
15 them. But a good number of them don't really need this kind
16 of unique service.

17 I think the parameter that Sam has in his definition
18 is a very important one. It is if this additional handicap
19 or more than one would of itself require special education
20 services.

21 Thinking about rubella kids, you know, the ones with
22 as far as we can determine almost normal vision, we feel that
23 they could be served in programs for the deaf.

24 MISS TAYLOR: But they don't.

25 DR. HATLEN: But they don't.

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1 DR. MYKLEBUST: Let's come back to this. I thought
2 we were getting away from this for this reason: That I think
3 we have agreed that here is a youngster -- and I'm illustrating
4 -- with only a straight-across audiogram of 35 decibels, using
5 the old system, not the new ISO system, which would be 45.
6 But say 35 decibels. Now, this youngster has a learning dis-
7 ability rather severe. Neither of these alone would put him
8 in special education. It is the fact that he has both of them
9 that puts him in special education.
10 I think then that what Sam has here is very important
11 -- that each of them might require special services in itself.
12 But Evelyn's point is, and I think part of Bill
13 Wolfe's point is, that you have another group of children
14 that you wouldn't pick up at all that way. You would include
15 here children who because they have more than one involvement
16 require special education, not either one alone. Is that
17 right?
18 DR. DENO: That's right.
19 MISS TAYLOR: I think Phil has just brought this out
20 in pointing out the children who seem to have practically
21 normal vision --
22 DR. MYKLEBUST: Yes, he has.
23 MISS TAYLOR: -- are not acceptable to a program for
24 the deaf, you see.
25 DR. MYKLEBUST: That's right.

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1 MISS TAYLOR: Actually, if you view their handicaps
2 separately, they would not possibly go into two separate special
3 education programs, but the combination makes it different.
4 DR. MYKLEBUST: This is very good. So under No. 3
5 how does this approach it? Some of these would require special
6 education services in and of themselves. Each of them in and
7 of themselves. Others require special education services be-
8 cause of the -- here we are -- more than one, see, multiple,
9 more than one, involvement, combination.
10 All right.
11 DR. DENO: Because of multiple interaction effect.
12 DR. MYKLEBUST: That's the idea I'm trying to get to.
13 DR. RIDGWAY: Are you saying that No. 3 would come
14 first but there is another group who --
15 DR. MYKLEBUST: That's right, Bob, only I was putting
16 them both in No. 3. I don't know if that's the way to do it.
17 DR. RIDGWAY: Haven't we done this in No. 1? What I'm
18 saying is No. 1 now moves under No. 3 as the second half.
19 DR. MYKLEBUST: Could be, yes. But I agree with Phil
20 on this point of Sam's that a lot of these-- Yes, either one
21 alone would require special education. I think this is a good
22 criterion.
23 I think it is also important that we include a group
24 of children where one of the handicaps wouldn't require special
25 education but the two together do, the two or more together do.

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I think this is a very important group, yes.

DR. WOLFE: I have tried to borrow or have borrowed from everything that has been said here, and I have tried to come up with this definition:

The term "multiply-handicapped" refers to those individuals with a combination of problems or deficits each of which may require special educational techniques. When these multipl deficits exist, they produce a unique interrelated effect on development and learning and therefore require unique combinations of special educational approaches.

DR. MYKLEBUST: Well, Bill has said a lot here for us. That's a lot of what we are talking about, isn't it?

DR. WOLFE: It is nothing new. I borrowed from everything else here.

DR. MYKLEBUST: I'm going to ask Bill to read this again and see whether we have these parameters in and whether we are ready to start looking at a definition like this in more, well, specific terms, not final terms.

Will you note, all of you, whether we have these parameters included? And we could move on from that.

Bill, go ahead.

DR. WOLFE: The term "multiply-handicapped" refers to those individuals with a combination of problems or deficits each of which may require special educational techniques. When these multiple deficits exist, they produce a unique interrelate

1 effect on development and learning and therefore require unique
2 combinations of special educational approaches.

3 DR. MYKLEBUST: Frank Hewett, we are using the term
4 "multiply-" here. Do you want to comment? What do you think
5 about it in this connection?

6 DR. HEWETT: Well, I think it probably not going to do
7 us too much good if we just get hung up on the label itself.

8 I don't know whether "multiple disabilities" or
9 "the multiply-disabled child" is any closer to education than
10 the "multiply-handicapped" and whether we could use-- I tend
11 to like it a little better, but again I think it's too close
12 to "learning disabilities" perhaps.

13 DR. MYKLEBUST: I think I'm right you're using the
14 term "multiply-handicapped," Bill?

15 DR. WOLFE: I personally do not like the term "handi-
16 capped." I never have.

17 DR. MYKLEBUST: It's very difficult to get away from
18 though, isn't it?

19 DR. WOLFE: You could say the "multiply-involved"
20 or "a child with multiple problems," something of this sort.

21 DR. RIDGWAY: How about "multiply-impaired"?
22 We have said visually impaired, so "multiply-impaired."

23 One thing I'm thinking about in the definition is that
24 we must be careful that a youngster with two or more learning
25 disabilities as they were defined yesterday would not be

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included under this definition.

DR. MYKLEBUST: Yes. We have to watch that. I think you're right.

"Multiply-handicapped." Okay. That's one way. "Multiply-involved." "Multiple deficits." The term Bill is using, the phrase, is "the term 'multiply-handicapped.'" "The term 'multiple deficits."

Bob suggests "The term 'multiple impairment' refers to."

Any preferences here or other suggestions?

DR. WOLFE: I start out using "multiply-handicapped" and then in the second sentence I say, "when these multiple deficits."

DR. MYKLEBUST: Yes, I like that myself. But any other comments on the leadoff here? Yes, Jo?

MISS TAYLOR: I like "multi-handicapped" because the dictionary does not have a prefix "multiply-." There is "multi."

DR. MYKLEBUST: It has "multiple" though.

MISS TAYLOR: "Multiple" but not "multiply-."

DR. MYKLEBUST: "Multiple" is the preferred term. This is quite right, Jo.

That is a good correction. I think "multiple" would be the preferred term. Actually it is the only term, as Jo points out. I think that's right.

1 MISS TAYLOR: "Multi."

2 DR. MYKLEBUST: Yes, but that's a little unwieldy
3 here, isn't it -- multi-handicapped?

4 DR. SELZNICK: May I throw out another possibility?

5 DR. MYKLEBUST: Yes.

6 DR. SELZNICK: One of the reservations I think some of
7 us may have is that this statement has a connotation for other
8 than educational purposes. We have come to identify the word
9 "handicap" et cetera.

10 DR. MYKLEBUST: Yes.

11 DR. SELZNICK: Now, what if the statement were some-
12 thing along this line: In some children one will identify--
13 And then-- I had it in my mind a few moments ago. So that it
14 focuses on the child and his response to learning situations
15 rather than the emphasis on the word "handicap."

16 DR. MYKLEBUST: Well, again I think the point is
17 very well taken here. What do you think about "multiple
18 involvement" or "multiple impairments" to get beyond this point,
19 Harrie?

20 DR. DENO: I like the word "impairment." I think it
21 is consistent with what we say in the others -- vision and
22 hearing impairment.

23 And also to me the term "impair" has a connotation
24 of function in it like "handicap" does too, because in some
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25 measurable kind of way there might be deviation there, but the

1 word "impair" implies that it is interfering with something.

2 DR. MYKLEBUST: Yes.

3 I wonder, Frank Hewett, would this term "impairment"

4 be more acceptable in the emotionally disturbed.

5 DR. HEWETT: We don't normally think of emotional

6 impairment.

7 DR. MYKLEBUST: I know. That's why I'm concerned.

8 DR. HEWETT: Social impairment? Emotional impairment?

9 Learning disabilities too. Impairment is maybe more related

10 there. We are thinking of perhaps neurologically based impair-

11 ment. It's very difficult, and I don't think probably it should

12 be held up because these more functional social, emotional

13 areas don't tend to be contained in the same nomenclature.

14 DR. MYKLEBUST: I sense we really feel "handicapped"

15 isn't the best term here. "Involvement" is probably too neutral

16 and doesn't really tell us very much. "Impairment" seems to

17 be preferred. We don't want "multiple disabilities," do we?

18 Because then we fall right into the learning disability one,

19 don't we?

20 DR. BLAIR: Yes.

21 DR. MYKLEBUST: You see, I suspect then we are in

22 trouble with what we did yesterday.

23 So we narrow down to "multiple impairments" then, do

24 we?

25 DR. RIDGWAY: Will this communicate with the field

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all right? You know, if there are laws already on the books that talk about "multiple handicaps" or things like this, then just because a group of a dozen or 15 of us get together and make up a new term doesn't really mean much.

DR. MYKLEBUST: That's right. It can delay action on the part of our recommendations for years of course.

In this State-- Am I right? Let's see. No one can check me here. Jim, you can. In our State I think it is "multiple handicaps." I'm pretty sure it is -- the terminology.

DR. HEWETT: These are handicapped children and youth in Washington? This whole batch of youngsters?

DR. KASS: Handicapped children.

DR. HEWETT: I just wonder, Corrine, do you think that is important to preserve that kind of a consistency?

DR. KASS: It might be a point.

DR. SELZNICK: What about "multiple deficits" which we used in the earlier definition?

DR. MYKLEBUST: It comes in the second part of what Bill has. We could change that, Bill, so the initial could be changed, and you could change your second part when we start working the rest of it.

But "multiple deficits" also tends to overlap with yesterday to some extent.

I'm going to ask Bill to read that again to see how "multiple deficits" is used.

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1 Go ahead, Bill.

2 DR. WOLFE: You mean the second sentence or all of

3 it?

4 DR. MYKLEBUST: Read the whole thing again.

5 DR. WOLFE: As I had it originally? I have not

6 changed it. If I were to change it to "impairment," we are

7 going to have to change then the rest of it, because we are

8 referring to individual --

9 DR. MYKLEBUST: No, read it the way you have it.

10 DR. WOLFE: The term "multiple handicap" refers to

11 those individuals with a combination of problems or deficits

12 each of which may require special educational techniques. When

13 these multiple deficits exist, they produce a unique inter-

14 related effect on development and learning and therefore requir

15 unique combinations of special educational approaches.

16 DR. MYKLEBUST: Now, you see, there are several terms

17 used there, "deficits" and "multiple involvement" I believe.

18 Now, there is a question here again whether we want

19 to preserve the term "handicap."

20 Harrie, would you have serious objections to pre-

21 serving it here?

22 DR. SELZNICK: No.

23 DR. MYKLEBUST: I said I agreed with Harrie. I have

24 no serious objection to preserving it. I think the point is

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25 well taken here that there might be considerable delay in

1 our separating ourselves from the term -- I mean delay in
2 terms of accomplishing services and so on.
3 So what do you think? Is the term "handicap" here
4 the best we can come up with?
5 DR. BLAIR: I think we should leave it.
6 DR. WOLFE: In view of the Office program, I think we
7 should, though I don't like the term.
8 DR. MYKLEBUST: It seems, doesn't it, Bill, it is
9 very difficult to get a better one?
10 DR. WOLFE: I think we should tie it in with the
11 Federal program.
12 DR. ASHCROFT: I do like the term, because there are
13 impaired children I don't want to work with. I don't want to
14 work with them unless they are handicapped.
15 DR. MYKLEBUST: I see your point.
16 Evelyn made a point a while ago that "handicap" is
17 a functional determination.
18 DR. WOLFE: It's a very negative term though.
19 It's unable, below par, not up to snuff. It's all negative.
20 DR. BLAIR: But isn't that what we're talking about?
21 DR. WOLFE: I'm talking about the effect this term
22 has upon the person who has the problems.
23 DR. MYKLEBUST: You always run into that, of course,
24 after a term is used a while.
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25 DR. HATLEN: Frank, do you use the term "emotionally

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1 handicapped"?

2 DR. HEWETT: I don't. I use "emotionally disturbed."

3 Eli Bauer tried to put "emotionally handicapped" in the books

4 because he felt "emotional disturbance" tended to make it look

5 like the kid was upset with behavior problems rather than a

6 kid whose emotions were handicapping him.

7 DR. MYKLEBUST: I think that's favorable though --

8 that the term "handicapped" has been used in emotional disturb-

9 ance. It's favorable to our point here.

10 DR. HEWETT: That's right.

11 DR. DENO: I don't think we gain enough from changing

12 from "handicapped" to do it.

13 DR. MYKLEBUST: No. It seems that we are really not

14 gaining very much. Are we?

15 We will then proceed with the rest of this, and I

16 would like to start having this on the slate now, because we

17 are going to have to look at all these words, Bill.

18 Lou, would you help us again, please?

19 Evelyn, do we have this down? Because we are going

20 to have to see if we have to make changes here to include

21 the parameters here.

22 DR. WOLFE: The term "multiple handicap" refers to

23 those individuals with a combination of problems or deficits

24 each of which may require special educational techniques. When

25 these multiple deficits exist, they produce a unique interrelated

1 effect on development and learning and therefore require
2 unique combinations of special educational approaches.
3 DR. HEWETT: Do you think that "producing unique inter
4 related effect on development and learning" should come in the
5 first sentence and "requiring special educational techniques"
6 in the second?
7 When these multiple handicaps exist, they may require
8 special educational techniques. In other words, --
9 DR. WOLFE: I see what you mean.
10 DR. HEWETT: Is one more basic to the definition than
11 the other?
12 DR. WOLFE: Yes.
13 DR. RIDGWAY: I think you can take out the qualify-
14 ing business too -- "when they exist." We are saying there is
15 such a thing, so we don't need the "when" part. Take out "when".
16 Capital "T" on "these." Knock out "exist" and "they."
17 DR. ASHCROFT: Does this handle the combination of
18 problems that wouldn't meet the criteria for special education
19 services in and of themselves? You see, the "these" refers
20 to "each of which requires."
21 No, I guess it refers to "problems" or "deficits."
22 But this doesn't seem to handle that child who should be in-
23 cluded even though neither or any of his problems meets the
24 criteria.
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25 DR. WOLFE: You could take out "these" then, Sam.

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1 Just say, "Multiple deficits produce a unique interrelated
2 effect." Wouldn't that handle what you are saying?
3 MISS TAYLOR: Yes. I wonder if we might not con-
4 sider taking out "combination of," too, and just say "require
5 unique special educational approaches." It may be something
6 besides combinations of.
7 DR. MYKLEBUST: Go ahead, Bob.
8 DR. RIDGWAY: I was wondering if in order to make
9 certain that this can't be confused with learning disabilities
10 it would be helpful in the definition to stick in a parentheti-
11 cal phrase after "problems or deficits" and put in something
12 about, say, mental retardation, blindness, and so on, in
13 parentheses.
14 DR. MYKLEBUST: "Such as"?
15 DR. RIDGWAY: Yes, in order to make certain that
16 everybody knows we are talking about categories, --
17 DR. MYKLEBUST: Yes.
18 DR. RIDGWAY: -- rather than the things we were dis-
19 cussing yesterday.
20 DR. MYKLEBUST: All right.
21 DR. RIDGWAY: Another problem that I have is this
22 "unique interrelated effect." I don't see this as quite the
23 thing we were talking about earlier. I mean the term "inter-
24 related" doesn't mean the same thing to me as --

25 DR. DENO: Interactive.

ERIC

1 DR. RIDGWAY: -- as "interaction."

2 DR. WOLFE: I was using "interrelated" there to sup-

3 port the program, because you have to have something to tie

4 that onto.

5 DR. BLAIR: Could we put another one on the board

6 and look at it? Would this be appropriate, Mr. Chairman? Or

7 do you want to work on this one?

8 DR. MYKLEBUST: No, we can modify and have combina-

9 tions, Frank, like yesterday. We had three or four to work from.

10 And I think there are others here that have other suggestions.

11 Bill's I think was the most definitive statement that we had,

12 and we got started on this.

13 But, as yesterday's, I think we all assume we may have

14 to add and delete and so on.

15 Do you have one there now, Frank, that you finished?

16 DR. BLAIR: Yes.

17 DR. MYKLEBUST: All right.

18 DR. BLAIR: Do you want me to write it?

19 DR. FLIEGLER: That would be easier.

20 DR. ASHCROFT: While he's doing that, an idea was

21 developed yesterday that I think was important. That is the

22 concept of educational planning. I think so often we tend

23 to think in terms of only a special class kind of provision

24 instead of a broader concept of special education services

25 that would be implied by special education planning.

ERIC

1 DR. MYKLEBUST: Right.

2 DR. DENO: I have that down kind of as a fourth
3 parameter, though we didn't write it.

4 Since the effect is unique in each case, the educa-
5 tional plan for each case is unique.

6 DR. FLIEGLER: The question I would have is: Do we
7 really mean the word "unique" or "different" or "unusual"?

8 "Unique" refers to that rare quality, one of a kind.
9 Are we getting ourselves into a bind there, you know?

10 DR. DENO: That was literally what I mean. That is
11 why I used it. But maybe that's not appropriate. Because I
12 think at least with the kind of children that we get falling
13 out of what we were talking about here, the standard systems
14 which we have developed, each of those kids stands out very
15 idiosyncratically.

16 DR. MYKLEBUST: Yes.

17 DR. DENO: I can't think of them in a cluster like
18 I think of visually impaired kids and hearing impaired kids.
19 They are just so different. They are such an accidental
20 combination of factors.

21 I think that is one of the reasons we have trouble
22 providing for them. And when we do provide for them, it is
23 usually, like Sam said, in some special center where we really
24 have drawn together a wide variety of services so that we
25 can organize it around the uniqueness of each case. Because at

1 this point we haven't developed a curriculum for teaching really
2 to deaf blind, have we?
3 DR. HATLEN: No. I don't think we want to.
4 DR. DENO: I don't think it would be worth it, because
5 I don't think there are enough of them.
6 MISS TAYLOR: We keep attaching on for the multi-,
7 multiple handicap because "deaf blind" doesn't really describe
8 it.
9 (Reporter's Note: The statement placed on the board
10 by Dr. Blair follows: "'Multiple handicap' refers to a condi-
11 tion of disability in which a combination of factors impede
12 learning. This condition should be viewed in terms of the
13 unique interactional effects of these factors on the process
14 of learning. The educational techniques for children with
15 multiple handicap must reflect the need for special programming
16 which extends beyond that which is usually provided for a single
17 disability.")
18 DR. MYKLEBUST: Thank you, Frank.
19 If I could just call your attention to-- Or, rather,
20 I think Corrine has something to call your attention to here.
21 But, first, Corrine, I will just read that. All right?
22 "'Multiple handicap' refers to a condition of disabil-
23 ity in which a combination of factors"--
24 We already think that term would have to be "deficits,"
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25 Frank, because it leaves it too general perhaps.

". . . of deficits impede learning. This condition should be viewed in terms of the unique interactional effects of these factors on the process of learning. The educational techniques for children with multiple handicap must reflect the need for special programming which extends beyond that which is usually provided for a single disability."

Now, there are several parameters here that we have looked at this morning.

Now, Corrine, do you want to take that first sentence or whatever you want to --

DR. KASS: I think we might be able to take a combination of the two again and come up with a simple first sentence, and then with our elaboration, which would be something like:

"Multiple handicap" refers to a combination of deficits which impede learning and requires special educational techniques.

I was trying to get the "interactional effects" in here.

DR. MYKLEBUST: But you see the approach Corrine is suggesting here.

MISS TAYLOR: The interactional effect of which requires.

DR. KASS: Combination of deficits which impede learning.

DR. DENO: The interactional effect of which impede.

1 DR. KASS: The interactional effect of which requires
2 special educational techniques. And then we must go on to
3 define these.
4 DR. MYKLEBUST: Jo, would you write that in as one
5 sentence?
6 MISS TAYLOR: You wouldn't be able to read my writing.
7 DR. MYKLEBUST: I mean --
8 DR. RIDGWAY: We might --
9 DR. MYKLEBUST: Excuse me, Bob. Go ahead.
10 DR. RIDGWAY: I'm sorry. I was the impolite one.
11 DR. MYKLEBUST: Go ahead.
12 DR. RIDGWAY: I was suggesting to get Sam's notion
13 in here that we say "the combination of which or interational
14 effects of which" and then go on with the rest of that, get
15 it all in the basic sentence.
16 DR. MYKLEBUST: It sounds good to me. Jo, would you
17 get all of these down? Can you? And read them back to us here?
18 Or, Corrine, do you have them?
19 DR. KASS: "Multiple handicap" refers to a combina-
20 tion of deficits which impede learning, the combination of
21 which or the interactional effects of which require special
22 educational techniques.
23 The combination or interactional effects. I don't
24 think we have to say "of which" twice.

25 DR. RIDGWAY: No.

1 DR. KASS: The combination or interactional effects of
2 which require special educational techniques.
3 DR. MYKLEBUST: That's progress, isn't it? That's
4 a pretty good first sentence. It may need some further work,
5 but it is combining various aspects of what we are talking about
6 I think.
7 DR. WOLFE: It does leave out the point that Sam was
8 making originally -- that each one of these alone would qualify
9 for special education.
10 DR. MYKLEBUST: Yes. Presumably this has to be fol-
11 lowed up. Then we go on now.
12 DR. KASS: We should define "combination" and we should
13 de .ne "interactional effects." In other words, that sentence
14 would come under defining "combination of deficits" and then
15 the interactional effects would be defined as the unique --
16 DR. MYKLEBUST: Yes. I don't like to take these
17 off the slate, because there are several phrases here that might
18 help us in further definition, like "usually provided for in
19 a single disability," "special programming," and "combination
20 of special education approaches." But we need these before us.
21 Do we have these down so we could start over again, so to speak,
22 and get some of this put together up here?
23 Do we have it down? All right, Lou. I think Corrine
24 has the first sentence here. Do you want to read it for us,

25 Corrine?

1 DR. KASS: "Multiple handicap" refers to a combination
2 of deficits which impede learning, the combination of inter-
3 actional effects of which require special educational techniques.
4 Now, we should define "combination of deficits."
5 DR. HATLEN: Would "planning" be better than "tech-
6 niques"?
7 DR. DENO: Or "programming"? And how long can the
8 sentence be? Because you could go on and say "programming
9 beyond that required for children with a single disability" and
10 run it all up in one sentence.
11 DR. MYKLEBUST: Let's try it. Would you put the other
12 terms up there, Lou?
13 Special education program.
14 DR. DENO: Planning.
15 DR. HELLER: Services.
16 DR. MYKLEBUST: Planning.
17 DR. KASS: "Services" is good.
18 MISS TAYLOR: Services.
19 DR. MYKLEBUST: Now, Evelyn, go on from there, please.
20 DR. DENO: Beyond that required for the education of
21 children with a single disability.
22 DR. RIDGWAY: You had better say "handicap" here
23 instead of "disability."
24 DR. MYKLEBUST: Let's put in "handicap."

25 DR. FLIEGLER: You said "programming," didn't you,

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1 Evelyn?

2 DR. DENO: Yes.

3 DR. MYKLEBUST: Now, how should we proceed? Shall we

4 stay with this statement now before we go on and define the

5 terms? How does this statement come through for us?

6 DR. HEWETT: Pretty good.

7 DR. MYKLEBUST: Bob?

8 DR. RIDGWAY: I like the addition that was made on

9 the other one -- combination of deficits, sensory, motor,

10 emotional, or learning disability.

11 DR. DENO: In parentheses.

12 DR. BLAIR: That makes it a little bit long now, I

13 think.

14 DR. KASS: We can put it under the definition of

15 "combination of deficits," if we use this as the phrase to be

16 defined.

17 DR. DENO: To follow the pattern we used in the one

18 yesterday.

19 DR. HELLER: We can use that other combination though

20 in the second line, because if you have interaction you have

21 got to have a combination.

22 DR. HEWETT: Interactional effects of which?

23 DR. FLIEGLER: Is this consensus Texas style?

24 DR. HEWETT: How about it, Bill?

25 DR. WOLFE: Right.

1 DR. ASHCROFT: I think this is a new question, but
2 I'd like to raise it. I'm wondering about other terms than
3 "learning," such as "development" or "adjustment." Or is
4 "learning" broad enough to cover everything we mean?
5 DR. DENO: We are trying to stay with the educational
6 orientation, aren't we? Our special responsibility is to facil-
7 itate learning.
8 DR. RIDGWAY: We used "development and learning" be-
9 fore.
10 DR. KASS: That's good.
11 DR. FLIEGLER: Shall we just throw it in there?
12 DR. MYKLEBUST: Let's throw it in. Which impede
13 development and learning. Sam, how do you like that?
14 DR. ASHCROFT: I think that's all right.
15 MISS TAYLOR: I'd like to put "unique" back --
16 require unique special educational techniques.
17 DR. ASHCROFT: We said "beyond that required."
18 MISS TAYLOR: I thought that would eliminate having
19 that long sentence.
20 DR. SELZNICK: Do we really have two sentences there
21 rather than one?
22 DR. MYKLEBUST: Excuse me, Harrie. Lou, did you have
23 something?
24 DR. FLIEGLER: There was a suggestion on the "unique."
25 Where did you want that, Jo?

1 MISS TAYLOR: Well, I think we should leave the longer
2 phrase instead. I thought we could just cut it shorter.
3 DR. MYKLEBUST: All right then, Harrie. How would
4 you divide that into two sentences?
5 DR. SELZNICK: After the word "learning," capital "T"
6 on "the," and, "The interactional effects of these. . ."
7 DR. DENO: Of the combination of defects?
8 DR. SELZNICK: Yes.
9 DR. MYKLEBUST: Would you prefer to have this in two
10 sentences is the question. And that would change No. 2.
11 Go ahead.
12 DR. KASS: We could keep it in one sentence if we
13 said "which impede development and learning."
14 DR. MYKLEBUST: That's the way we have it.
15 DR. KASS: And producing interactional effects which
16 require.
17 DR. MYKLEBUST: You'd have to have "which impede
18 development and learning."
19 DR. KASS: Producing.
20 DR. MYKLEBUST: And produce.
21 DR. KASS: And produce. And produce interactional
22 effects which require.
23 If we are agreed. We are agreed, aren't we, on the
24 interactional effects and it should be part of this sentence?
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25

1 DR. MYKLEBUST: Interactional effects which require
2 special educational techniques.
3 DR. WOLFE: Is that "impedes and produces"? It refers
4 to combination, doesn't it?
5 MISS TAYLOR: Yes.
6 DR. HELLER: Of deficits impeding learning and pro-
7 ducing.
8 DR. BLAIR: It's the combination which impedes. Is
9 that what you're saying?
10 DR. WOLFE: Yes. It should be "impedes" instead of
11 "impede." Singular, isn't it?
12 DR. KASS: "Combination" is a bad word.
13 DR. BLAIR: "Impedes," Lou.
14 DR. HEWETT: And "produces."
15 MISS TAYLOR: "Combinations" would say it.
16 DR. KASS: Why couldn't we say "refers to inter-
17 action of deficits which impede development"? No, no good.
18 DR. DENO: Combination of interacting deficits.
19 DR. KASS: A combination of interacting deficits.
20 DR. HEWETT: Two or more deficits.
21 DR. DENO: We also said "a combination of interacting
22 deficits" as a possibility.
23 DR. RIDGWAY: That negates the notion that all of them
24 don't necessarily interact.
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25 DR. KASS: That's right.

1 DR. MYKLEBUST: That's right.

2 MISS TAYLOR: I like the idea of having the "combina-
3 tions." Because there are a variety of combinations that occur.
4 And you can leave your "impede" the way it was.

5 DR. MYKLEBUST: "Refers to combinations." Take out
6 "a." "Refers to combinations of deficits which impede." Take
7 out "s."

8 "Which impede development and learning and produce
9 interacting"-- Or "interactional"?

10 DR. KASS: Interacting.

11 DR. MYKLEBUST: Interacting. Which produce inter-
12 acting effects requiring special education planning services--
13 Which require special education -- period.

14 DR. HEWETT: Don't we have to put something like "for
15 remediation"? It's hanging there.

16 DR. MYKLEBUST: Yes.

17 DR. KASS: Yes.

18 DR. HEWETT: These effects are produced and require
19 the techniques.

20 DR. KASS: "Services" would be all right, wouldn't it?

21 DR. HEWETT: "Services" would be.

22 DR. KASS: Services.

23 DR. HEWETT: The techniques to do something.

24 DR. KASS: I like "services."

25 DR. MYKLEBUST: Which require special education

1 services. All right?

2 All right, Lou -- "services." Which require special

3 education services.

4 DR. ASHCROFT: This is the field of multiple choice

5 definition. (Laughter)

6 DR. HEWETT: Proceed in multiple choice. (Laughter)

7 DR. WOLFE: Are you going to leave that phrase at

8 the end -- "beyond that required"?

9 DR. DENO: "Beyond those," then.

10 DR. WOLFE: "Beyond those" then.

11 DR. FLIEGLER: All right. I think we are ready for

12 voting. Yes, Bob?

13 DR. RIDGWAY: The "produce interacting effects" could

14 be changed, and we could say "and interact to produce effects."

15 Isn't that what we are really talking about? These conditions

16 don't produce effects. They interact.

17 DR. DENO: That's better.

18 DR. MYKLEBUST: Which interact to produce effects.

19 DR. DENO: Or "produce educational needs," if we want

20 to get back to the education.

21 DR. FLIEGLER: Which interact?

22 DR. MYKLEBUST: And produce.

23 DR. HEWETT: Could you put "impeding" then to get

24 rid of the "which"? The combinations of deficits impeding

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25 development and learning.

1 DR. CHALFANT: I'm not sure I'm reading this properly.
2 Are we saying "multiple handicaps" refers to combinations of
3 deficits? Now, I'd like to put something in -- "which inter-
4 act and"-- Let's see.
5 "Which interact then and result in development and
6 learning problems or produce. . ."
7 DR. DENO: Which interact.
8 DR. CHALFANT: In other words, put the "interact"
9 right after the "deficits." It's the deficits that interact
10 and produce this.
11 DR. MYKLEBUST: It's "interact and impede" -- "which
12 interact and impede learning."
13 DR. CHALFANT: Yes.
14 DR. FLIEGLER: All right.
15 DR. MYKLEBUST: Which interact and impede learning --
16 impede development and learning and produce effects.
17 DR. DENO: Mike, don't they interact to impede rather
18 than "interact and impede"? I mean the interaction produces
19 the impediment. They interact to impede.
20 DR. HEWETT: Just "require special educational
21 services." You get rid of the "which."
22 DR. MYKLEBUST: That's good.
23 DR. HEWETT: And which require.
24 DR. CHALFANT: And require.

25 DR. DENO: In ways which require.

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1 DR. FLIEGLER: I just want to get these up here and
2 then we can take our choices.
3 DR. MYKLEBUST: Now, we have deficits which interac
4 to impede development and learning. Where are we?
5 DR. WOLFE: And which require.
6 DR. HEWETT: Which require special education servic
7 DR. DENO: "And" is always weak. Can we say "inter
8 act to produce effects which"?
9 DR. MYKLEBUST: Interact to impede development and
10 learning. That is what we have.
11 DR. DENO: In ways which require special education
12 techniques.
13 DR. HEWETT: So that special education techniques a
14 required.
15 DR. MYKLEBUST: We don't have "in ways" up there.
16 In ways which require special education services beyond those
17 Now, we can't use "require" again. Beyond those planned
18 typically for children --
19 DR. BLAIR: Normally provided.
20 DR. MYKLEBUST: Beyond those typically provided, if
21 you'd wish, for children with a single handicap. I think tha
22 "beyond" is an important addition.
23 DR. WOLFE: That's good.
24 DR. FLIEGLER: There was something I lost here.

25 DR. MYKLEBUST: Which require special education

1 services -- that's it -- beyond those --

2 DR. FLIEGLER: Okay.

3 DR. MYKLEBUST: -- typically provided for children with

4 a single disability.

5 DR. RIDGWAY: Handicap.

6 DR. MYKLEBUST: Now, Bob suggests that last word

7 should be "handicap," and you see it's up there -- for children

8 with a single handicap.

9 DR. FLIEGLER: May I suggest something?

10 DR. MYKLEBUST: Yes.

11 DR. FLIEGLER: If I may. Could we start backwards

12 in a sense? We have a lot of suggestions up there, and that

13 may be our problem. Are we comfortable with this phrase,

14 "indicating"? Let's change just this phrase back here (indi-

15 cating phrase beginning with "beyond."). I think you all agree

16 it needs to be in there.

17 DR. MYKLEBUST: How would you do it, Lou? What do

18 you mean?

19 DR. FLIEGLER: Well, do we want "handicap" or "dis-

20 ability"?

21 DR. HELLER: I don't think you're being uniform if

22 you use "handicap" and/or "disability" there when you are

23 using "deficits" up above. You are referring back to a deficit

24 Why not call it a deficit?

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25 DR. FLIEGLER: All right.

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1 DR. HELLER: With a single deficit.

2 MISS TAYLOR: We are also calling it "multiply-

3 handicapped."

4 DR. ASHCROFT: Can you work from the end without the

5 antecedents?

6 DR. HEWETT: You have to start from the beginning.

7 DR. FLIEGLER: Your phrase won't change here. This

8 is what I think everybody is agreed on. This is my suggestion.

9 Everybody is talking about beyond that, beyond those typically

10 provided. In other words, a word may change, but this from

11 what I have been gathering here-- I don't know. Everybody

12 agrees that this must go in.

13 DR. DENO: It's a criterion.

14 DR. FLIEGLER: That's right. It's one of the para-

15 meters. So all I am saying is it would be simpler for us to

16 start just to throw this in.

17 Now, we can go back to it, but everybody feels this

18 ought to go in.

19 DR. DENO: Lou, with respect to that, it seems to

20 me yesterday too when we used the word that it "required"

21 special education services this was an index. The word "re-

22 quire" was an index. So this also says in ways which require

23 special education services beyond that.

24 And then we went to "typically provided," which is

25 weaker because it doesn't say anything about requirement. It

1 just says about what we ordinarily do.

2 DR. MYKLEBUST: Yes, I was thinking --

3 DR. DENO: So why don't we say "those needed for

4 children with a single disability" or something like that?

5 DR. MYKLEBUST: We can use the word again. I was

6 just trying to avoid redundancy.

7 DR. RIDGWAY: It's stronger to have "require" both

8 places.

9 DR. MYKLEBUST: That's right. I'm sorry I suggested

10 it. I think we should use "required" both places. Both places.

11 Okay?

12 DR. DENO: Yes.

13 DR. MYKLEBUST: Beyond that required. Let's take

14 out that "typically provided." I was just trying to get away

15 from using the same word twice, and here you need it twice.

16 DR. FLIEGLER: Beyond that required -- or needed?

17 DR. MYKLEBUST: Required.

18 DR. KASS: Make it "those" to go with "services."

19 DR. FLIEGLER: All right. Beyond those. Beyond those

20 required for children with a single -- disability, handicap,

21 deficit?

22 DR. HEWETT: Handicap really. Doesn't it refer back

23 to "multiple handicap"?

24 DR. FLIEGLER: Okay. Handicap.

25 All right. "In ways." Shall we leave that in? That'

1 a qualifier.

2 DR. MYKLEBUST: Ways which require special education

3 services.

4 DR. FLIEGLER: All right. In ways which require

5 special education services.

6 Okay. Now we can I think go to the antecedents and

7 play with that.

8 DR. RIDGWAY: Let's erase what we don't need over here

9 now.

10 DR. FLIEGLER: Okay. What is it that we can agree

11 on?

12 DR. RIDGWAY: Start with "require" and knock the rest

13 of it out.

14 DR. FLIEGLER: Do you want "which" in there? Because

15 we have "in ways."

16 DR. RIDGWAY: We don't need that.

17 DR. FLIEGLER: I will leave these terms up there be-

18 cause they might be discussionable (indicating terms "programs,"

19 "planning," "services," and "programming.")

20 DR. RIDGWAY: The interaction business can come out,

21 because we have it earlier.

22 DR. HEWETT: Interactional effects.

23 DR. RIDGWAY: That can come out.

24 DR. WOLFE: Second line.

25 DR. MYKLEBUST: Would it help if we had Lou read this

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1 now? Lou, can you read it?

2 DR. FLIEGLER: Not really. (Laughter)

3 "Multiple handicap" refers to --

4 DR. KASS: Combinations. Erase the top.

5 DR. FLIEGLER: Okay. "Multiple handicap" refers to

6 combinations of deficits which interact to impede development

7 and learning and produce --

8 DR. HELLER: In ways.

9 DR. FLIEGLER: -- in ways which require special educa-

10 tion services beyond those required for children with a single

11 handicap.

12 DR. MYKLEBUST: Jim?

13 DR. FLIEGLER: Wait a minute. May I just get this

14 down?

15 DR. MYKLEBUST: One moment, Jim.

16 DR. FLIEGLER: Which interact to impede development

17 and learning. Okay.

18 DR. MYKLEBUST: Now, Jim.

19 DR. CHALFANT: Would this be grammatically correct --

20 I'm not sure -- if you omitted "in ways which" and put "and"

21 there? I'm not sure when I read this whether it comes out

22 properly or not.

23 DR. RIDGWAY: The notion was that "and" was a weaker

24 word.

25 DR. CHALFANT: All right. I was trying to cut down.

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1 DR. MYKLEBUST: Phil, go ahead.

2 DR. HATLEN: The term "beyond"-- Does that infer
3 that we are saying that these services need to be something
4 even more than we provide for other groups of handicapped
5 children? Or do we mean different from those required?

6 DR. MYKLEBUST: This is a very interesting question,
7 and I'd like some reaction.

8 My own feeling, Phil, was that the term was rather
9 beautifully inclusive and could include all of this, that it's
10 beyond-- I thought of it as something other than what we now
11 do but it refers to what we do but something else in addition.
12 So it is rather an innovation.

13 Now, some other reaction?

14 MISS TAYLOR: Yes. "Beyond" to me implies this idea
15 I thought we were trying to get away from of building upon what
16 we already have.

17 DR. MYKLEBUST: That's right.

18 MISS TAYLOR: Rather than developing something unique.
19 And I would think that "other than" or something like this
20 would be more appropriate to what we would hope to give these
21 children.

22 DR. MYKLEBUST: Then you think "beyond" doesn't say
23 it?

24 MISS TAYLOR: No.

25 DR. MYKLEBUST: I thought it was saying it very well.

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1 Education services beyond, you see -- other than, in addition
2 to and beyond.
3 Yes, Corrine?
4 DR. KASS: What about the phrase "services in addi-
5 tion to"?
6 DR. WOLFE: It's not necessarily in addition to. It's
7 different from certainly.
8 DR. KASS: It might be.
9 DR. MYKLEBUST: Yes.
10 DR. ASHCROFT: I like "different."
11 DR. WOLFE: The word "unique" might have helped.
12 MISS TAYLOR: That's right.
13 DR. MYKLEBUST: This might be the term. I would just
14 ask you. Does this mean now that you can't use anything of the
15 other? I think "beyond" was something where you use what you
16 had now but more. Go ahead.
17 DR. ASHCROFT: Well, there are those multiple handi-
18 capped children in disability categories who will be served
19 in the category whose problems are not so different or so
20 severe --
21 DR. MYKLEBUST: That's true.
22 DR. ASHCROFT: -- in such combinations that --
23 DR. MYKLEBUST: That's true exactly. You would use
24 what, Sam?
25 DR. ASHCROFT: Different from.

1 DR. MYKLEBUST: All right.

2 DR. FLIEGLER: May I also go back to something that
3 you have been reiterating that strikes a responsive chord? I'm
4 not sure I can prove it.

5 That is, you talk about a psychology of learning, what
6 I call behavioral science in special education.

7 DR. MYKLEBUST: Right.

8 DR. FLIEGLER: Then you made the point quite clearly
9 that perhaps for these kids there is a new or different set
10 of learning principles which we have to evolve.

11 DR. MYKLEBUST: I like that very much. Anyone else?

12 DR. DENO: Would it help to say "which require a
13 special education services system different from those required
14 for children with a single handicap"? That would allow you to
15 bring in different combinations of things.

16 DR. FLIEGLER: Could we go back to what Sam said?
17 I'm sorry. I didn't mean to interrupt.

18 DR. MYKLEBUST: Go ahead, Lou.

19 DR. FLIEGLER: The word "planning"-- Is this what
20 you mean, Sam? See, this is an administrative term to some
21 degree. Whereas "planning" is-- Is this what you were getting
22 at, Sam?

23 DR. ASHCROFT: Not in this most recent comment, but
24 earlier I was.

25 DR. MYKLEBUST: Jim?

1 DR. CHALFANT: I'm not unhappy with "services."
2 Another word that might be used here could be "special education
3 programming."
4 DR. DENO: We have got that over there.
5 DR. CHALFANT: Yes, it's over there.
6 DR. BLAIR: I think there is a point here about
7 "services." You're right, Lou. It is administrative. It does
8 have that connotation. And we are talking here about educa-
9 tional needs, which, of course, does involve services and so
10 on, but we are talking about methodologies too.
11 DR. FLIEGLER: What's your pleasure?
12 DR. DENO: Does the word "accommodations" then give
13 it to you?
14 "Instructional accommodations" or something?
15 MISS TAYLOR: How about "services and techniques"?
16 DR. BLAIR: Something like "approaches."
17 DR. MYKLEBUST: Now, "approaches" hasn't been up there
18 Do you want to put it on, Lou, just to see how we come out here?
19 Now, Frank Hewett stepped out, but you noticed a
20 while ago he was objecting to "programming" and so on as not
21 meeting some of the requirements of the children that we are
22 talking about.
23 So I think we should see whether "services" did fill
24 the need for some of this.
25 That was his opinion then. So I think we are shiftin

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1 emphasis in a way if we get off here. We would want to consider
2 it carefully before we go ahead.
3 In ways which require special education programming
4 systems, approaches-- Frank, we're getting away from a term
5 you had. Help us out.
6 DR. HEWETT: Sure. I'm glad I came back in time.
7 (Laughter)
8 DR. MYKLEBUST: The term "services" is being ques-
9 tioned there, Frank. And you wanted "services" in.
10 "Programming systems," "approaches," or something else.
11 But now "services" is being questioned. And you had a special
12 reason for wanting "services."
13 DR. HEWETT: It was just it seemed if you didn't have
14 "services," you needed something like "for remediation."
15 If these interactions impede development in ways
16 which require special educational something for something,
17 "services" was all-inclusive.
18 If it is "approaches" in order to do something --
19 DR. MYKLEBUST: Yes. Well, Jo is suggesting two
20 terms. I'm afraid we're coming to two terms. Services and
21 remediation or something.
22 MISS TAYLOR: Techniques.
23 DR. DENO: Yesterday we used the term "remediation"
24 though to refer to disability which had the potential for

25 correction.

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1 DR. HEWETT: Can be corrected.

2 MISS TAYLOR: That's why I was using the word "tech-
3 niques," because I think beyond the special services we also
4 have to think in terms of special techniques.

5 DR. MYKLEBUST: Joe, I think "approaches" really says
6 something too. Special education approaches and remediation?

7 MISS TAYLOR: And techniques.

8 DR. MYKLEBUST: You don't want two?

9 Okay, Bob.

10 MISS TAYLOR: I want two, but not the word "remedia-
11 tion," because we have used that so much with special education.

12 DR. MYKLEBUST: Excuse me.

13 DR. DENO: What about "special approaches to educa-
14 tion different from those required to"?

15 DR. MYKLEBUST: Now I have to slow you down so you
16 can each one come in on this.

17 Bob, you're next.

18 DR. RIDGWAY: I don't like the word "approaches,"
19 because this means you are getting close to something. And I
20 think we want to hit it.

21 DR. MYKLEBUST: I see.

22 DR. RIDGWAY: "Services," as has been pointed out,
23 and "systems" also are administrative terms.

24 "Programming" or "planning" are the two that --

25 DR. HEWETT: We kicked out "techniques," did we?

1 DR. MYKLEBUST: No, not yet.

2 DR. HEWETT: That's not up there.

3 DR. FLIEGLER: I'm sorry. I was objecting to "tech-

4 niques." (Laughter)

5 DR. MYKLEBUST: Bob, are you through?

6 DR. HEWETT: "Instructional techniques" would be

7 better, wouldn't it?

8 DR. RIDGWAY: I like "programming" or "planning,"

9 either, better.

10 DR. MYKLEBUST: One at a time, please. Bob likes

11 "programming" and "planning."

12 DR. RIDGWAY: The "techniques" bother me a little,

13 because there are things other than techniques involved, as

14 we mentioned earlier.

15 DR. MYKLEBUST: Okay. Now Harrie.

16 DR. SELZNICK: I was leaning to "educational inter-

17 vention."

18 DR. MYKLEBUST: Another term, "intervention."

19 DR. SELZNICK: And removing the word "special.

20 DR. MYKLEBUST: Bill?

21 DR. WOLFE: I don't like the word "remediation."

22 Let me start back that far.

23 I had the opportunity to look up the word "remedy."

24 Do we really know what that means? I was surprised to find

25 out some of the meanings of that thing. It means to correct,

1 reverse, and we are not going to do that with these kids.

2 DR. KASS: Right.

3 DR. WOLFE: So I think we have to throw that out.

4 I personally like "programming." It says that we have

5 to give thought to producing something different. I would say

6 "programming different from that required for children with

7 a single handicap."

8 DR. MYKLEBUST: Now, if I could just for a moment--

9 Harrie, why do you want "special" out? Because of our trying

10 to really relate this to special education-- I was wondering.

11 Do we really want to consider this suggestion of Harrie's?

12 Are we going to say "special" has a real place in this?

13 DR. SELZNICK: I'll tell you why very simply.

14 DR. MYKLEBUST: All right.

15 DR. SELZNICK: I think special education really is

16 not easily definable. I think special education relates to

17 an administrative package. It includes a number of related

18 but independent, independently prepared and provided, services.

19 I think that's about --

20 DR. MYKLEBUST: But we have a field of special educa-

21 tion.

22 DR. SELZNICK: Yes, but I don't know what it means.

23 I frankly don't know what special education means in a broad

24 sense -- although I have devoted a life to it.

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25 I am the Director of Special Education, but really it

1 means something-- It means that I have a responsibility for
2 a variety of programs and services.
3 DR. WOLFE: I move we pick up his cards. (Laughter)
4 DR. SELZNICK: That's all right. You'll be doing me
5 a favor. (Laughter)
6 But I think it's a question we ought to be able to
7 answer ourselves.
8 DR. MYKLEBUST: I think you're quite right in a
9 philosophical sense. I wonder though if we don't jeopardize
10 our intent and purposes by becoming too general here.
11 It would seem to me-- Corrine, you wanted to say
12 something?
13 DR. KASS: No. I would agree. I think that our
14 focus has been special education, and we have been saying these
15 require something specific. So I think --
16 DR. WOLFE: It would seem to me for all of the single
17 problems special education would have the responsibility, but
18 when they get more difficult, in the area of the multiply
19 handicapped, we are going to let just regular education take
20 care of that.
21 DR. SELZNICK: No, --
22 DR. MYKLEBUST: Jim is next.
23 DR. CHALFANT: There are two ways you might look at
24 this "special." You could look at it in terms of special
25 education, which I think you are doing, or you might look at it

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1 in terms of special educational programming, special educational
2 planning.
3 DR. HEWETT: It sounds like you can put them all on
4 teaching machines if you have programming. I think that's a
5 funny word.
6 DR. MYKLEBUST: Very much in that direction. Program-
7 ming really does come into teaching machines.
8 Yes, Bill?
9 DR. HELLER: I like the word originally, "services,"
10 because if you work with multiple handicapped children I think
11 you not only are working in a classroom situation but there are
12 other administrative, organizational, planning -- everything
13 that impinges upon this particular type child that may not
14 on another. So it is a range, a broad scope.
15 I don't think we want to be exclusive here. I think
16 we want to be a little more inclusive.
17 DR. MYKLEBUST: I think the comment is well taken.
18 Sam, you're next.
19 DR. ASHCROFT: Let me propose we say "in ways which
20 require special education different from that required for
21 children with a single handicap."
22 DR. HEWETT: You took all the fun out of it. (Laughter)
23 DR. MYKLEBUST: How do you like that?
24 DR. WOLFE: It takes us off the hook.

25 DR. HEWETT: In ways which require special education?

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1 Golly. Does that follow?

2 DR. BLAIR: That's really broad now.

3 DR. DENO: That would have to assume that we agree

4 that special education is a program of services so that we

5 are using "special education" like a noun.

6 DR. MYKLEBUST: That's what we are doing.

7 DR. BLAIR: It seems to me we are talking about ser-

8 vices. We are also talking about techniques. We have got to

9 provide for both of these. And I think either word alone

10 doesn't satisfy me.

11 DR. MYKLEBUST: Now, Frank Blair, you're saying you

12 don't think you can leave out any-- What is it?

13 DR. BLAIR: No, it seems to me that we are talking

14 as much about special techniques which may be provided in a

15 variety of ways, perhaps within existing programs or perhaps

16 in new innovative programs. And if we say "services," I think

17 it suggests that there has to be innovation. And I'm not

18 sure this is always true. I think we are going to operate

19 many of these kids in current kinds of programs.

20 DR. MYKLEBUST: Now, I think we have all had a good

21 chance to really explore this, and I must say that I see ad-

22 vantages to Sam's suggestion. I also see some disadvantages

23 which Frank is emphasizing. I think Sam would be happy to go

24 along with the group's decision if they want to put a word

25 in here. I would be happy to go along with it.

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1 I wonder if "services" -- if we put a word in --
2 isn't the one that most of us feel says what most of us mean.
3 Can I ask the question that way?
4 I think the term "systems," "programming," and
5 "approaches" have essentially here in our discussion been con-
6 sidered more limiting, hence not as useful.
7 And Harrie's suggestion-- Harrie, I think the group
8 says they think the term "special" adds to it. I don't think
9 you would be concerned greatly if we left it in as a designa-
10 tion, let's say, even though it may not fit with the philosoph-
11 ical concept that you are raising. It might be useful here.
12 I am trying to resolve our various feelings about
13 this and raise the question this way: Could we agree that we
14 leave "special" in, leave "services" in, and go on to further
15 discussion of other aspects of this which will need looking at
16 next?
17 DR. HEWETT: Is it appropriate to leave it just
18 "special education" or should there be "special educational
19 services"?
20 DR. MYKLEBUST: I was wondering about that, too. I
21 think grammatically this is a little bit off, though it depends
22 a little bit on how we are using it I guess.
23 Would you like "requires special educational services"
24 You see, Frank, that's a little different emphasis

25 than what we were talking about. We were really talking about

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1 special education as a noun.

2 DR. HEWETT: Right.

3 DR. MYKLEBUST: And most of the time I think most of

4 us have felt -- and that's what concerned me about this term

5 "special" -- that we are relating this to an activity organized

6 within our culture in the school systems, and it is this area

7 of effort that we are talking to, you see -- in ways which

8 require this area of effort --

9 DR. HEWETT: That's right.

10 DR. MYKLEBUST: -- to do something different from that

11 which we do for children with a single handicap.

12 DR. HEWETT: "Special educational" can become an

13 offshoot of something they do in the regular classroom kind of

14 thing where this is identified with a discipline or --

15 DR. MYKLEBUST: That's the intent.

16 DR. HEWETT: Yes.

17 DR. MYKLEBUST: All right. Lou, let's take it out

18 now and see-- We can always come back.

19 Now, we left off "instructional techniques." And

20 you can take off those other words. Combinations of deficits

21 which interact to impede development and learning in ways which

22 require special education services different from those re-

23 quired for children with a single handicap.

24 I'd like to compliment you on a beautiful sentence,

25 beautiful statement. I really think you have said a great deal

1 I really do. I think it's a very nice statement.

2 Now, mind you, I am aware that we all compromise a
3 little in these, but I think that this is a very good statement
4 for many purposes for these children.

5 Shall we now consider what we do next? First, let's
6 take another break.

7 (Whereupon, a recess was taken.)

8 DR. MYKLEBUST: Now, this is a very good statement.
9 I really believe that we can't improve on it.

10 Well, there is the next step which I would like to
11 suggest that we think about for the rest of the morning, and
12 that is this: How might now this definition be interpreted?
13 How can we as a group suggest that this definition be applied
14 to help people working with the child who has both visual
15 and auditory impairment or the retarded child who has visual
16 impairment, and so on?

17 What are the implications here in terms of the people
18 that are confronted with this problem?

19 To some extent now, if you like, we can talk about
20 training. But I would rather first try to anticipate some
21 of the many implications.

22 Bob Ridgway, do you want to comment on this?

23 DR. RIDGWAY: It seems to me the definition was made
24 necessary because of the confusion that exists among all of us

25 when we make applications for training funds and the confusion

1 that existed on the panel knowing how to react to proposals.

2 One of the-- Well, I'm really not able to react to

3 this very well without reference to training.

4 DR. MYKLEBUST: Yes. Well, we'll be happy to have you

5 go on with that.

6 Corrine, go ahead.

7 DR. KASS: Well, may I suggest that where we might

8 break this down into the various combinations is to take the

9 phrase "combinations of deficits which interact" with a state-

10 ment about the statement Sam made, each of which might require

11 special education services, and the idea of interaction, and

12 then take the various combinations of interaction and perhaps

13 discuss each of these in turn.

14 DR. FLIEGLER: This is our clarification?

15 DR. KASS: Clarification and discussion of the

16 combinations.

17 DR. MYKLEBUST: All right.

18 DR. DENO: Lou, you changed the last word when you

19 rewrote that.

20 DR. FLIEGLER: I did? I'm sorry.

21 DR. MYKLEBUST: Now, Corrine is suggesting the

22 approach we used yesterday -- that is, to go ahead now and say

23 what we refer to, or, rather, something of what we indicate

24 here.

25 So the first one that we take up would be "combinatio

1 of deficits."

2 Corrine, could you take that?

3 DR. KASS: Yes. I would take all of it -- "combina-

4 tions of deficits which interact" -- rather than breaking these

5 apart, and then show that these might be two separate or three

6 separate handicaps which could be dealt with in each of these

7 ways or interaction of deficits and then provide examples of

8 this by talking about the deaf blind, blind retarded, and

9 interacting --

10 DR. MYKLEBUST: Yes.

11 DR. DENO: This would be the place we would bring in

12 Bob's point before. That is, the deficits referred to include

13 such as mental retardation, blindness. You know. You were

14 talking about putting in that parenthetical statement in order

15 not to confuse it with the combination of learning processes

16 which we included under disability, learning disability.

17 DR. MYKLEBUST: All right, Phil.

18 DR. HATLEN: Maybe prior to this would come something

19 like what was done yesterday, which was the second paragraph

20 kind of elaborates on the term "learning disability," which

21 isn't necessarily definitive, but it does elaborate on it.

22 And maybe we need to elaborate on "multiple handicap."

23 I just put this down, and this can't be used because

24 it is too much like this sentence in words. But "multiple

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25 handicap" refers to those children who are handicapped in more

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1 than one of the following areas -- and then just repeat the
2 areas which were eliminated yesterday, sensory, motory, intel-
3 lectual, emotional. And then include learning disabilities in
4 that list. Because this would be one, too.
5 But this would come before what you are talking about
6 I guess (to Dr. Kass).
7 MISS TAYLOR: It's the same thing, isn't it? Isn't
8 that what you are saying? Just in different words?
9 DR. HATLEN: You're breaking them down even further,
10 though.
11 DR. MYKLEBUST: Now, if I may, I would like to have
12 these suggestions up there, Lou, if we can. Take Phil's. He
13 has something before here.
14 "Multiple handicap" refers to what, Phil?
15 DR. HATLEN: To those children who are handicapped
16 in more than one of the following areas.
17 DR. MYKLEBUST: "Multiple handicap" refers to chil-
18 dren --
19 DR. HEWETT: If we replace "deficits" with "handi-
20 capping conditions," we could just take out "handicapping
21 conditions" and expand it. You can't do it with deficits so
22 easily.
23 But would that be easier? In place of "deficits"
24 in the original put "handicapping conditions," and then go and
25 say, "handicapping conditions" refer to -- because that is reall

1 what is essential here.

2 The "interacting and impeding" isn't essential to re-

3 define, is it, or to include in a clarification?

4 DR. KASS: Well, --

5 DR. MYKLEBUST: All right, Corrine.

6 DR. KASS: In the first place, I think you are really

7 starting another definition of "multiple handicap," which we

8 already defined. In other words, the clarification comes into

9 taking that part of the definition which needs elaboration and

10 clarification.

11 DR. MYKLEBUST: I think this is the attempt here,

12 yes.

13 DR. KASS: The suggestion I am making is that we

14 have to take the combinations and interaction together because

15 we are saying that the interaction is what produces another

16 sort of child.

17 DR. RIDGWAY: I think what Phil is saying is that be-

18 fore you talk about combinations you need to know what you are

19 talking about -- sensory, motor, --

20 DR. HEWETT: Deficits.

21 DR. RIDGWAY: Et cetera. Deficits.

22 DR. KASS: Well, the "combinations of deficits" is

23 synonymous, isn't it? Synonymous with the various combinations?

24 No?

25 DR. RIDGWAY: What I see is that the combination is

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1 deaf blind, et cetera, et cetera.

2 DR. KASS: Yes.

3 DR. RIDGWAY: But at least following your suggestion

4 we would list what we mean by "handicaps."

5 DR. DENO: The deficits referred to are such deficits

6 as blindness, deafness, mental retardation.

7 DR. RIDGWAY: Yesterday we said we are talking about

8 things that are not included in sensory, motor, intellectual,

9 and emotional problems. Now the suggestion is we are talking

10 about combinations of sensory, motor, intellectual, et cetera.

11 DR. KASS: All right.

12 DR. RIDGWAY: We still have to do the thing you sug-

13 gested -- talk about the combinations and their interaction.

14 DR. MYKLEBUST: Now, then, we are giving clarification

15 of what a multiple handicap means.

16 DR. DENO: What kind of deficits we are talking about.

17 DR. MYKLEBUST: I just want to be sure I'm clear.

18 DR. HEWETT: It's the deficits that we first have

19 to clarify. Isn't that right? Then the combination. That's

20 the word that really is ambiguous there.

21 DR. MYKLEBUST: Well, then, you are saying-- That's

22 what Corrine is saying, isn't it? I think we are not quite

23 clear.

24 Yes?

25 DR. RIDGWAY: Phil, I think we'd clear this up if,

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1 instead of saying "'multiple handicap' refers," we say
2 "'handicap' refers to" and then list the conditions. Then go to
3 "combinations of deficits which interact," as Corrine has sug-
4 gested, and explain this phrase.

5 DR. KASS: What you're doing then is redefining or
6 defining in other words, "multiple handicap."

7 DR. RIDGWAY: No, --

8 DR. FLIEGLER: No, he's elaborating.

9 DR. RIDGWAY: Knock out the word "multiple."

10 DR. SELZNICK: And start with "handicap."

11 DR. RIDGWAY: "Handicap" in this sense refers to.

12 DR. BLAIR: Do you think that's necessary, Bob? It
13 seems to me that's assumed, isn't it?

14 MISS TAYLOR: Why don't we use the thing where we --

15 DR. HEWETT: "Deficits" is the ambiguous word here.

16 DR. MYKLEBUST: One at a time. We'll let Bob finish.
17 Bob?

18 DR. RIDGWAY: It seems to me that you can elaborate
19 on "handicap" or you can elaborate on "deficit," either one.
20 But Corrine had wanted to talk about the combination of deficits
21 which interact.

22 DR. MYKLEBUST: Right.

23 DR. RIDGWAY: As a single term.

24 DR. MYKLEBUST: Let me ask you, Bob: Why do you think
25 you have to put that in here? Why do you have to say something

1 about what a handicap is?

2 DR. RIDGWAY: In order to differentiate between this

3 definition and the definition of learning disabilities, so that

4 nobody gets confused about this.

5 DR. MYKLEBUST: I see.

6 DR. RIDGWAY: If we are just talking about combina-

7 tion of deficits, this could be --

8 DR. MYKLEBUST: I see your point now.

9 DR. KASS: Oh.

10 DR. HEWETT: Perceptual.

11 DR. MYKLEBUST: Yes, that's right. Jim, do you want

12 to come in here?

13 DR. CHALFANT: No. He said it.

14 DR. MYKLEBUST: All right. Then "handicap" refers to

15 or means-- What do you want, Bob?

16 DR. RIDGWAY: The group we used yesterday -- sensory,

17 motor, intellectual, emotional, or learning disability. I

18 think you add it.

19 DR. DENO: Yes.

20 DR. HEWETT: Then what does "deficit" refer to?

21 DR. FLIEGLER: Let's play with that. We have to get

22 something in here (indicating), Bob.

23 DR. MYKLEBUST: You do. Impairments?

24 DR. FLIEGLER: Impairments in sensory -- in the

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25 following areas, or something.

1 DR. HEWETT: Just put "impairments" at the end.
2 Sensory, motor, intellectual impairments and learning dis-
3 abilities.
4 DR. FLIEGLER: You put something in there?
5 DR. HEWETT: Put in "impairments" after "intellectual"
6 and tag on learning disabilities.
7 DR. MYKLEBUST: Yes, you can. All right. Fine.
8 DR. FLIEGLER: Which of these two words? Handicap?
9 DR. KASS: Handicap.
10 DR. FLIEGLER: Make a choice for me. Do you want
11 to leave it that way for a while?
12 DR. MYKLEBUST: Frank, you think it's "deficits,"
13 don't you?
14 DR. HEWETT: That seems to me the word that needs
15 to now --
16 DR. MYKLEBUST: It does to me.
17 DR. HEWETT: I'd like to replace "deficits" with
18 "handicap" again. "Multiple handicap" refers to combinations
19 of handicaps or handicapping conditions. I think "deficits"
20 just-- It's a funny word. It doesn't fit there. I think we
21 ought to keep it in the family a little more.
22 DR. KASS: Yes.
23 DR. BLAIR: I agree.
24 DR. MYKLEBUST: Let's try it out this way. We're
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25 going back to the original now. "Multiple handicap" refers to

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1 combinations of handicaps, Lou. I think if we don't have to
2 put in "handicapping conditions," we're a little better off.
3 Combinations of handicaps. Now you have to take off
4 "in ways."
5 DR. BLAIR: No, which interact.
6 DR. MYKLEBUST: I'm sorry. It's over there. Excuse
7 me. Which interact to impede development and learning. I'm
8 sorry. All right? Agreed? That's fine.
9 Jim?
10 DR. CHALFANT: If we're going to do this, then could
11 we say "combinations of handicaps" refers to two or more im-
12 pairments in sensory and so forth?
13 DR. MYKLEBUST: Corrine, this gets to your point.
14 Does that --
15 DR. CHALFANT: This comes back to Corrine's point.
16 DR. MYKLEBUST: We can do this in this way, Corrine,
17 perhaps.
18 DR. KASS: Yes.
19 DR. MYKLEBUST: Go ahead, Jim.
20 DR. CHALFANT: We get in trouble with "impairments"
21 again. "Combinations of handicaps" refers to --
22 DR. DENO: Why don't you say "multiple handicaps"
23 refers to combinations of sensory --
24 DR. KASS: No, no. That's just repeating.
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25 DR. CHALFANT: Then we have our definition again.

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1 Refers to two or more. Now we have to make a modification.

2 DR. KASS: That's all right.

3 DR. CHALFANT: Wait a minute. No, we don't. That's

4 good. Refers to two or more sensory, et cetera.

5 DR. HEWETT: Get rid of that second "refers to." Is

6 there any way?

7 DR. ASHCROFT: Can you say "and/or learning disabil-

8 ities"?

9 DR. WOLFE: It's not right the way it is there. It's

10 not correct.

11 DR. SELZNICK: I wrote, "The 'multiple handicap'

12 refers to those with two or more deficits in" -- and then the

13 last part of the sentence.

14 DR. WOLFE: That wouldn't be right either.

15 DR. FLIEGLER: There was something you were trying

16 to tell me. I got a little lost.

17 DR. MYKLEBUST: Go ahead.

18 DR. FLIEGLER: Jim?

19 DR. CHALFANT: "And/or learning disabilities" at

20 the end.

21 DR. FLIEGLER: I see. Okay. And/or.

22 DR. CHALFANT: The only thing here is when you take

23 out "deficit" you are defining the term with one of the words

24 of the term. You are defining "handicap" with "handicap."

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25 DR. WOLFE: Where?

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1 DR. MYKLEBUST: Where is this?

2 DR. CHALFANT: You have "multiple handicaps" and then

3 this refers to combinations of handicaps.

4 DR. HEWETT: That's exactly what it is.

5 DR. BLAIR: You're going on to explain it.

6 DR. CHALFANT: All right.

7 DR. KASS: You don't need that "and/or."

8 DR. MYKLEBUST: Corrine doesn't think you need "and/

9 or."

10 DR. KASS: You are saying two or more.

11 DR. CHALFANT: Okay.

12 DR. WOLFE: Wait a minute. Wouldn't that mean then

13 he would have to have one of the others and the learning dis-

14 ability?

15 MISS TAYLOR: Yes.

16 DR. KASS: Two or more of --

17 DR. HEWETT: He'd always have to have a learning dis-

18 ability.

19 DR. WOLFE: He'd always have to have a learning

20 disability.

21 DR. KASS: Two or more sensory, motor, emotional,

22 intellectual --

23 DR. MYKLEBUST: Intellectual type impairments or

24 learning disabilities.

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25 DR. KASS: Or. I guess "or."

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1 DR. FLIEGLER: "Or"?

2 DR. WOLFE: Then that would say anyone with learning

3 disability would have a multiple handicap.

4 DR. MYKLEBUST: When you put "or" in, does it?

5 What does?

6 DR. WOLFE: The "or."

7 DR. MYKLEBUST: Then we can't use that. I think we

8 are in trouble here with that.

9 DR. FLIEGLER: Remember this-- Oh, okay.

10 DR. RIDGWAY: Do we need an "or" between "emotional"

11 and "intellectual"?

12 DR. MYKLEBUST: Sensory, motor, emotional, intellec-

13 tual impairment or learning disabilities. Yes. Another "or"

14 does not do it, does it? Now, "and/or" doesn't do it, does it?

15 DR. FLIEGLER: Could I try something? Two or more

16 impairments in-- Would that help?

17 DR. DENO: Sensory, motor, emotional, intellectual,

18 or learning disability areas.

19 DR. SELZNICK: Function.

20 DR. WOLFE: Learning disability isn't a function.

21 DR. FLIEGLER: Yes, but you have the "impairments"

22 there which qualifies it. Is that getting what you are trying

23 to say?

24 DR. DENO: Or "deficits" there.

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25 DR. FLIEGLER: Two or more impairments.

1 DR. ASHCROFT: Change "disabilities" to "character-
2 istics."
3 DR. FLIEGLER: Two or more impairments or deficits?
4 And over here functions and characteristics?
5 DR. BLAIR: I don't think so, Lou. We have made
6 "learning disabilities" a generic term now, and it has to be --
7 DR. FLIEGLER: That's right. That's what I was going
8 to refer to.
9 DR. MYKLEBUST: You'd have to take out-- Oh, yes,
10 "impairments" comes out over here.
11 DR. FLIEGLER: "Impairments" would come out.
12 DR. MYKLEBUST: "Or learning disabilities."
13 DR. FLIEGLER: There is an "area" here somewhere.
14 MISS TAYLOR: How would it be if we said "combination
15 of handicaps" refers to two or more of the following -- learning
16 disabilities, sensory, motor, intellectual, emotional or motor
17 impairments?
18 DR. CHALFANT: She almost has it there, I think.
19 DR. MYKLEBUST: Yes, that's close.
20 DR. CHALFANT: Learning disabilities and sensory,
21 motor, emotional, intellectual impairments.
22 MISS TAYLOR: Leave out the "and" because that makes
23 it sound as though it has to be-- Just a comma.
24 DR. MYKLEBUST: Now, singular, Jo, not plural. Learn-
25 ing disability. Okay?

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MISS TAYLOR: Yes.

DR. FLIEGLER: Two or more of the following. Right?

DR. MYKLEBUST: Yes. First learning disability.

MISS TAYLOR: Then a comma.

DR. MYKLEBUST: Learning disability -- comma.

Go ahead, Jo.

MISS TAYLOR: Sensory, motor, intellectual, emotional or motor-- Oh, I have "motor" twice. Sorry. What's the other one? Impairments.

DR. DENO: Emotional. Do you have that?

DR. MYKLEBUST: We have the following: Learning disability-- Now, let's take them again, please. Sensory, --

MISS TAYLOR: Where is our list up there?

DR. MYKLEBUST: Go ahead, Jo.

MISS TAYLOR: Sensory, motor, emotional, or intellectual impairments.

DR. HEWETT: Would "involve" replacing "refers to" make it smoother? Combinations of handicaps involve two or more of the following, so we don't get the double "refers to" from the first sentence.

DR. MYKLEBUST: Let's put in "involves" and take out the other. Involves two or more of the following: learning disability, sensory, motor, emotional, or intellectual impairment.

DR. HEWETT: Singular, isn't it? Combinations of

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1 handicaps involved?

2 DR. MYKLEBUST: You're right. That's correct.

3 Now, that has come a long ways. How is it going?

4 Yes, Bob?

5 DR. RIDGWAY: Do we need "learning disability," or is

6 this an intellectual impairment? I know why we put it in there,

7 but --

8 DR. MYKLEBUST: The "intellectual" refers to the re-

9 tarded now. "Learning disability" is a separate category.

10 DR. BLAIR: It's generic now, we hope.

11 DR. MYKLEBUST: Otherwise we haven't done anything

12 about learning disabilities.

13 MISS TAYLOR: Well, maybe we should say "retardation"

14 instead of "intellectual impairment," and then we can avoid

15 that.

16 DR. MYKLEBUST: Yes.

17 DR. DENO: Sensory, motor, emotional impairment or --

18 MISS TAYLOR: -- retardation.

19 DR. KASS: Why don't we use "emotional disturbance"

20 too, as long as we are going to use terms which are most

21 commonly used.

22 DR. RIDGWAY: Sensory or motor impairment, emotional

23 disturbance, or mental retardation.

24 DR. KASS: Sensory or motor impairment, emotional

25 disturbance, or mental retardation.

1 DR. SELZNICK: It's a long term. I think the definition is stronger with "intellectual impairment." I think eventually the light is going to be seen, and "mental retardation" will be less commonly used.

DR. BLAIR: But right now, Harrie, I think it communicates more directly what we are trying to say. We should try to use current terminology.

MISS TAYLOR: I was trying to get around that idea of learning disability being intellectual impairment.

DR. RIDGWAY: This is picky, but is there a particular order which we should use here?

DR. MYKLEBUST: Do you have any suggestion?

DR. HEWETT: Just that mental retardation might belong before emotional disturbance, that kind of thing. You might move from the physical through kind of physical to --

DR. KASS: We can put mental retardation right here after learning disability.

DR. HELLER: I don't know. Jo here has a point -- mental retardation and the intellectual impairment.

If you speak of a child who is a slow learner in conjunction with another handicap, he wouldn't fit.

MISS TAYLOR: Yes. And particularly thinking about when it is in combination, as Mike has pointed out, you might consider a person who had a little more than retardation still belonging in a special program of that type.

1 DR. ASHCROFT: Can you introduce a little more flexi-
2 bility too so that cultural deprivation, for example, or-- I'm
3 thinking of combinations of handicaps. You know. A "such as"
4 clause so that you don't close the door.
5 DR. MYKLEBUST: But, you see, these are separate prob-
6 lems and are really-- I think we can't-- I don't like the
7 term "jurisdiction," but I don't think we can in this area of
8 special education get into what the cultural deprivation problem
9 means or represents here, Sam, again on the basis of the fact
10 it's manipulation of environment and opportunity rather than
11 defect.
12 I think that we will not be able to justify any in-
13 clusion of this cultural deprivation aspect in this definition.
14 DR. HATLEN: You included something yesterday though
15 that belongs in here someplace I think, and that is lack of
16 opportunity to learn. Maybe it is covered in some other area,
17 but --
18 DR. MYKLEBUST: Well, we included it yesterday, Phil,
19 in the sense it was not our problem. We said "does not include"
20 those with lack of opportunity to learn." And that is still
21 true today. And that's what I am saying.
22 DR. DENO: Also here we did before, at least, when
23 we were talking about the parameters, say that this group of
24 children is a group who need educational services beyond that
25 which is typically provided. We changed the words, but the

1 concept is there.

2 So that the lack of opportunity in this instance

3 would have to be the lack of opportunity in the conventional

4 special education program.

5 DR. MYKLEBUST: That's right.

6 DR. DENO: That is, the screening lack of opportunity.

7 DR. MYKLEBUST: Yes. Now, this then reads this way:

8 "'Combinations of handicaps' involved two or more of the follow-

9 ing: learning disability" -- and we will come back to this

10 problem, Bill Heller -- mental retardation, sensory or motor

11 impairment, or emotional disturbance." Right? We need one more

12 "or."

13 DR. HEWETT: If you put emotional disturbance in the

14 very beginning, that would take care of it.

15 DR. MYKLEBUST: That's right. It would. Learning

16 disability, emotional disturbance, --

17 DR. KASS: All right. Or sensory or motor?

18 DR. MYKLEBUST: No, we're talking about "the following"

19 -- up there by "the following." Put "emotional disturbance"

20 in there.

21 DR. HEWETT: Then it goes from the social, emotional,

22 DR. MYKLEBUST: Emotional disturbance, learning

23 disability, mental retardation, sensory or motor impairment.

24 MISS TAYLOR: I'm back to not liking the "mental

25 retardation."

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1 DR. MYKLEBUST: I said we'll come back to it, and
2 that's where we are right now. Now, there is some feeling here
3 that the term "mental retardation" is not-- Thanks, Lou. Good
4 luck. -- is not as useful or, that is, has connotations which
5 some of our members would not like to include here.
6 Now, I'd like reaction of some of the rest of you in
7 this connection. I wouldn't have thought of this, but I see
8 your point. I think "mental retardation" is today used in a
9 fairly restricted sense, and I think this is what Harrie, Bill
10 Heller, maybe Jo are referring to.
11 So I would like you to consider what we might use
12 that would not jeopardize the intent of the practical implica-
13 tion and so on.
14 But let's at least consider possibilities for "mental
15 retardation" such as-- What did you say, Bill?
16 DR. HELLER: Well, the "intellectual impairment" is
17 acceptable.
18 DR. MYKLEBUST: Well, then --
19 DR. HEWETT: You don't need "impairment" then.
20 DR. MYKLEBUST: You would have intellectual, sensory,
21 or motor impairment. Is that all right, Frank?
22 DR. HEWETT: Yes.
23 DR. MYKLEBUST: Now, Harrie, how does that sound to
24 you?
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25 DR. SELZNICK: I prefer it, personally.

1 DR. MYKLEBUST: All right, Jo?

2 MISS TAYLOR: Yes, I think so.

3 DR. MYKLEBUST: Now, then, it reads like this -- and

4 check me, Corrine: "'Combinations of handicaps'"-- "'Combina-

5 tions of handicap'"-- That's singular, isn't it? "Handicap"?

6 Or is it plural? No, you have it plural. "'Combinations of

7 handicaps' involve two or more of the following: emotional

8 disturbance, learning disability, intellectual, sensory, or

9 motor impairment.

10 I like that. Okay? I think it's a good correction.

11 Don't you like it, Phil?

12 DR. HATLEN: I'm just a little bit reluctant about

13 the word "involve," and I wouldn't-- If this doesn't sound

14 right to anyone, I'll be very quick to drop it. But what

15 about "indicate a presence of"?

16 DR. DENO: I like that better myself.

17 DR. MYKLEBUST: I'm sorry?

18 DR. DENO: I like that better.

19 DR. MYKLEBUST: You like that better?

20 DR. HATLEN: I don't see how "involve" fits.

21 DR. MYKLEBUST: Combinations of handicaps-- Well, you

22 don't want "indicate" though, do you?

23 DR. DENO: The term "indicates" you see --

24 DR. MYKLEBUST: "Indicates" is difficult in a defini-

25 tion. "Combinations of handicaps" means presence of?

1 DR. DENO: Yes, means the presence of.

2 DR. HATLEN: Yes.

3 DR. MYKLEBUST: These are all exploratory here to see

4 if we all agree on this. The last one came out beautifully.

5 This one may.

6 Now, Phil, is that what you mean?

7 DR. HATLEN: Yes.

8 DR. MYKLEBUST: All right. Frank Hewett, is it what

9 you mean?

10 DR. HEWETT: "Means" is a funny word.

11 DR. WOLFE: Refers to the presence of.

12 DR. MYKLEBUST: Then we are back to "refers," which

13 we were taking out.

14 DR. WOLFE: I know.

15 DR. MYKLEBUST: But I think "means" isn't a good word

16 either.

17 DR. HEWETT: That's not really what we intend.

18 DR. MYKLEBUST: But you don't like "indicates," do

19 you?

20 DR. HEWETT: No, that doesn't --

21 DR. MYKLEBUST: It's a very indefinite term here,

22 and we don't mean just "indicating," Phil. We mean it is.

23 DR. HATLEN: Identifies?

24 DR. SELZNICK: Specifies?

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25 DR. MYKLEBUST: That's the kind of term we mean.

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1 Corrine, did you have a suggestion?

2 DR. KASS: No.

3 DR. MYKLEBUST: Combination of handicaps indicates--

4 Or what is better than that?

5 DR. WOLFE: Denotes.

6 DR. MYKLEBUST: Jo, you have a lot of words.

7 DR. WOLFE: Denotes.

8 DR. MYKLEBUST: How about "denotes"?

9 MISS TAYLOR: That's good.

10 DR. MYKLEBUST: "Denotes." I like that. Okay?

11 Bob Ridgway, all right?

12 DR. HEWETT: We don't need the "presence of" then,

13 do we?

14 DR. MYKLEBUST: No, you don't.

15 DR. BLAIR: I don't think you do.

16 DR. MYKLEBUST: You really don't, do you, Sam?

17 DR. ASHCROFT: Very good.

18 DR. MYKLEBUST: Two or more of the following. It

19 leaves it a little vague without something. The "presence of"

20 was something for me I find.

21 DR. DENO: Or the existence of.

22 DR. MYKLEBUST: Denotes the presence of, or denotes

23 the existence of. It gets awkward though. Do we need it?

24 DR. BLAIR: I think it stands the way it is.

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25 DR. MYKLEBUST: You're satisfied the way it is?

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1 DR. BLAIR: I think it stands.

2 DR. MYKLEBUST: All right.

3 (Statement on the board now reads: "'Combinations
4 of handicaps' denotes two or more of the following:. . .")

5 MISS TAYLOR: Can I throw in one more idea?

6 DR. MYKLEBUST: Sure. Go ahead.

7 MISS TAYLOR: At the end, could we say "or other
8 debilitating conditions"?

9 DR. BLAIR: How about "other health impaired"?
10 (Laughter)

11 MISS TAYLOR: I'm thinking of this "other," because I
12 really think that we do have a problem with children-- You
13 know the "tied in the crib" thing and that type of thing which
14 involves this lack of opportunity. Or there may be some others
15 that we haven't thought of. So this would give us a little
16 leeway.

17 DR. MYKLEBUST: My feeling is this is implied and
18 would be troublesome to tie in. I think you would be constant-
19 ly explaining what you mean by "other" -- other aspects,
20 factors.

21 It seems to me, Jo, we would be asking for difficulty
22 beyond what we would expect.

23 Yes, Phil?

24 DR. HATLEN: Maybe Frank can answer this for me. A
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25 blind child who spends his entire preschool experience in a

1 playpen when he comes to school is emotionally disturbed?

2 DR. DENO: I'd say he had a learning disability,

3 because yesterday we defined "learning disabilities" as being

4 essential processes of perception, and so on. And it would be

5 these things which he would lack.

6 DR. CHALFANT: Acuity.

7 DR. RIDGWAY: Is he a deprived child?

8 DR. HATLEN: Is he culturally deprived?

9 DR. HEWETT: He'd be emotionally disturbed, I'd say,

10 but that is perhaps-- That is a moot point really.

11 MISS TAYLOR: Socially maladjusted too.

12 DR. SELZNICK: Environmentally different.

13 DR. DENO: Harrie and I wouldn't have any problem.

14 We'd just serve him.

15 DR. SELZNICK: That's right.

16 DR. MYKLEBUST: He would, of course, be seriously

17 deprived in experience, and so on, which would implicate

18 perceptions, emotions, various things involved.

19 Go ahead, Phil, with your question.

20 DR. HATLEN: No, I'm just trying to be a little more

21 specific about what I think Jo was saying. These are the kind

22 of kids that we get in school whom we consider multiple handi-

23 cap. And if we try to pin down the cause, maybe we're not

24 hitting the definition.

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25 DR. MYKLEBUST: Yes. Now it seems to me you have the

1 freedom of interpretation of whether you want to classify this
2 as multiple involvement or, rather, a variation from the basic
3 norm group, which in this case would be the blind, and so on.
4 You have to meet his need. So I don't think you can spell all
5 this out in this.

6 MISS TAYLOR: No, and I think really what happens
7 to that child is included in this whole long list of other
8 impairments, you know, the motor, the --

9 DR. HEWETT: What about the delinquent kid, the social
10 problem? You have the category "social or emotionally malad-
11 justed? Is that what they sayin the Office?

12 DR. MYKLEBUST: Yes. They are not included here.

13 DR. HEWETT: No. Is a delinquent a kid who has got a
14 learning disability plus he's a delinquent? Is he a multiply-
15 handicapped kid?

16 DR. MYKLEBUST: Well, if you are asking me, I happened
17 to spend much of my time for five years -- not full-time, but
18 much of my time for five years -- as a chief psychologist in
19 the juvenile court in a rather tough industrial area in the
20 East. And I would have to say that I think he is very seri-
21 ously multiply-involved as I would see him.

22 In the first place, the incidence of hearing loss
23 is at least twice the average. The incidence of visual impair-
24 ment is three to four times the average.

25 Incidentally, visual impairment is running much higher

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1 than any single factor in our survey in the public schools --
2 much higher than any other single factor.
3 Now, maybe our criteria-- Maybe we set the criteria
4 too loose or something. But these youngsters tend over and
5 over again-- And, of course, a psychiatrist just wrote a book
6 on Lee Oswald which rather clearly in my opinion indicates he
7 was a severe learning disability individual from early life.
8 He wasn't able to read, write, spell, and so on, you see.
9 So there is a tremendous acting out on the part of
10 a lot of these.
11 Recently I had to spend a long time in court -- I get
12 subpenaed at the drop of a hat -- on this deaf mentally retard-
13 ed Negro man who assaulted a woman and killed her. He had
14 no lipreading, no speech, no sign language.
15 So, of course, I knew all about how to find out how
16 much intelligence he had. (Laughter)
17 Believe me, these are tough problems, aren't they?
18 I mean you are supposed to read his mind, you know.
19 But we did get him out of the electric chair.
20 Now, I'm saying there's lots of this involved in all
21 of this, Frank, and it is an extremely important question
22 socially. I think it is implied rather than spelled out in
23 terms of our special education definitions today and yester-
24 day.
25 DR. HEWETT: We didn't put "social" in yesterday

1 either, did we?

2 DR. MYKLEBUST: No, we didn't. Evelyn?

3 DR. DENO: We left speech out. Is that deliberate?

4 DR. MYKLEBUST: Yes, it is deliberate on my part.

5 I think of speech as a different entity here. But not language.

6 We put language in, verbal or nonverbal, in learning disability

7 yesterday.

8 DR. HEWETT: "Intellectual" covers speech here really.

9 DR. MYKLEBUST: That's a very good point we should

10 consider for a minute. Under learning disability we have verbal

11 and nonverbal according to yesterday, meaning language.

12 DR. DENO: Okay.

13 DR. MYKLEBUST: Now, an articulation defect I would

14 deliberately leave out if I am --

15 DR. BLAIR: Yes.

16 DR. DENO: I forgot it was in learning disability.

17 DR. MYKLEBUST: I would say that speech per se, arti-

18 culation, is not included at this time.

19 DR. WOLFE: How about stuttering?

20 DR. MYKLEBUST: Definitely not. And not cleft palate

21 speech. Cerebral palsy would be included under motor, and so

22 on. But if they have only articulation, they wouldn't be

23 included. They'd be included under the motor, you see.

24 DR. WOLFE: Where would you include stuttering?

25 DR. MYKLEBUST: Well, stuttering as a category is a

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1 difficult one, Bill, and I know nothing about speech, stuttering,
2 and so on. It's not my field, despite the fact I'm in the
3 School of Speech and in a department where this work is done.
4 I personally am not certified in any of it, and I have not been
5 trained. I was a psychologist, as you know.
6 So I feel that stuttering is not the kind of handicap-
7 ping condition that special education has been concerned with
8 and as such is not included.
9 DR. DENO: We provide it under special education pro-
10 grams though, and what we said up there was "multiple handicap"
11 refers to combinations of handicaps which interact in ways
12 which require special education services different from those
13 required for children with a single handicap. So there are many
14 instances in which we do have to draw in speech service in
15 combination with services for the orthopedically handicapped
16 or whatever.
17 DR. MYKLEBUST: And that is intended, isn't it?
18 DR. DENO: Yes.
19 DR. MYKLEBUST: And including those in all of these
20 categories that stutter, Bill, they would be in, like retarded
21 stutterers, emotionally disturbed stutterers. Of course they
22 would be in.
23 DR. CHALFANT: There is a point that seems to be
24 coming up here, and I'm not sure we have touched on it or not.
25 That is, there may be a child with a multiple handicap, and it

may be that you would treat this as two-- In terms of treatment it would be treated as two distinct handicaps as opposed to a child that has a multiple handicap, as Sam has indicated, where it would be something quite different.

In other words, you might have two handicaps where you wouldn't get the interaction that we are talking about here.

DR. MYKLEBUST: Like an articulation problem?

DR. CHALFANT: Like an articulation problem and a reading problem. You wouldn't get the interaction. A little bit, you know. If it affected the phonics, perhaps slightly.

DR. MYKLEBUST: Reading dyslexia. Now, reading disability as a total area, no. But dyslexia is in learning disability. So are all the aphasias. So are the spelling disorders. They are all in under learning disabilities.

DR. KASS: May I suggest something else? Since we are trying so hard to think of all the possibilities here, instead of being so concise on the handicaps, why don't we name everything that we can think of, deaf, blind, partially hearing, partially sighted?

DR. MYKLEBUST: It's extremely difficult, you know. You notice I sent something out to you in that connection in which I was just exploring. Actually, I have looked at it, and it has many loopholes in it and is not very useful. You can tabulate sort of thing. I wouldn't do it the way I sent it out to you again, because there are too many problems with it. I

1 think you run into all kinds of difficulties.

2 I think more generic terms have much more usefulness.

3 Most definitions try to spell out too much and become entirely

4 useless in a short time.

5 MISS TAYLOR: Too limiting.

6 DR. MYKLEBUST: Too limiting.

7 DR. SELZNICK: I agree.

8 DR. MYKLEBUST: Now, it is about time to break for

9 lunch. Any comment from you, Sam, on this this morning?

10 DR. ASHCROFT: No.

11 DR. MYKLEBUST: Corrine, anything else?

12 DR. KASS: No.

13 DR. MYKLEBUST: Anything else?

14 DR. HEWETT: Are we going to need to clarify "special

15 educational services" in addition?

16 DR. MYKLEBUST: Well, I thought, frankly, that we

17 would have to come back to this after lunch and see where to go

18 from here.

19 DR. HEWETT: Interaction or whatever?

20 DR. MYKLEBUST: There will be other considerations

21 necessary here.

22 DR. WOLFE: Would it totally be out of the question

23 to consider adding the word "speech" after "sensory" and before

24 "or"?

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25 "Intellectual, sensory, speech, or motor impairment"?

1 DR. BLAIR: I agree with Mike. I don't think that
2 speech belongs here, despite the identification of this in the
3 funding program. I think this is not, strictly speaking, special
4 education.
5 DR. MYKLEBUST: All right, Bill.
6 DR. HELLER: I might just mention in the Office they
7 are thinking of organizing branches now, and sensory will include
8 speech. In other words, sensory disorders will include vision,
9 speech, deaf.
10 DR. BLAIR: But, you see, speech and language are in
11 conflict here, and I think we are talking about language.
12 DR. HEWETT: That comes under "intellectual" really.
13 DR. BLAIR: No. Learning disability.
14 DR. HEWETT: That's right. But it could also come
15 under that.
16 DR. MYKLEBUST: Any other preference? Corrine, do you
17 have any other statement of preference?
18 DR. KASS: No.
19 DR. MYKLEBUST: I think the preference of the group
20 would be to not get involved in the rather long, arduous dif-
21 ficulties you can get into by putting the term "speech" in.
22 And I say this because speech itself-- Now, we might disagree
23 with this, and we could put it in. If we disagree with this
24 and want to, I think we should. But I think you all know that
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25 speech deliberately does not include itself under special

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1 education.

2 Now, there is a little movement under CEC at this

3 time. I don't mean CEC is agreeing, but they are trying to do

4 it through CEC -- to do the same with learning disability --

5 keep it out. "We don't want to be in education. We don't

6 want to be in special education." See?

7 Now, speech as a group obviously does not declare

8 themselves as part of education or special education. Now, how

9 are you going to handle this in terms of your classifications?

10 I don't know, Bill.

11 DR. WOLFE: But in the State program, as you pointed

12 out, we have it. We have this as a special educational service.

13 DR. MYKLEBUST: That's true. That's right. I agree.

14 That's right. That's where it falls.

15 DR. ASHCROFT: We are naming characteristics of

16 children too, not programs.

17 DR. MYKLEBUST: Yes. You're quite right. That's

18 right. It is not included now by the way we have defined the

19 other categories. It was not included under learning disability.

20 DR. ASHCROFT: That was my point earlier in loosening

21 this up. These are just illustrative, and someone will always

22 think of some combination that isn't covered. And if we had

23 a clause that would allow whomever wanted to be included to be --

24 DR. SELZNICK: Am I introducing a problem? We do

25 have sensory, et cetera, in there. Could we talk about

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1 "communication problems," which would be more inclusive, thinking
2 of the language?
3 DR. MYKLEBUST: As I said yesterday, the term is
4 almost useless in most scientific discussions today, and I think
5 education, because it simply doesn't mean anything. Do you mean
6 what Joe Lilley means in the Porpoise? You immediately get into
7 that. Do you mean what you talk about today in the language
8 of all forms of life? Do you know what the communication
9 theorist means? He doesn't even refer to language. The recent
10 book, "Language Theory," hasn't even mentioned symbol. They
11 are interested in-- Their term is "signals." This is strictly
12 at the programming signal level.
13 So communication in a school in which we get into a
14 lot of this has almost been thrown out.
15 I think many people would say that communication to-
16 day has to be defined in many ways or you aren't saying anything.
17 There is nonverbal communication. Look at the great work of
18 Hall, Edward T. Hall. He just joined our staff in Anthropology.
19 This is a fabulous work called "The Silent Language," which
20 isn't anything of what we are talking about. And it's com-
21 munication.
22 Jim?
23 DR. CHALFANT: Now, it has come up several times. I
24 can differentiate fairly well between learning disability and

25 mental retardation, but when I look at intellectual impairment

1 and learning disability I have trouble. I see overlap.

2 DR. MYKLEBUST: But there isn't in the definition

3 yesterday. We said they had normal intelligence. That is

4 strictly spelled out.

5 DR. CHALFANT: That's it. When I look at "intellec-

6 tual impairment," I'm thinking of something other than mental

7 retardation.

8 DR. MYKLEBUST: I see what you mean.

9 DR. CHALFANT: As Frank said, language is an intel-

10 lectual impairment.

11 DR. MYKLEBUST: That was with us yesterday and this

12 morning. That's right. So "intellectual impairment" is very

13 broad and doesn't necessarily mean mental retardation. No, I

14 think you're right.

15 DR. BLAIR: But it could.

16 DR. HATLEN: What Sam suggested is put the word "may"

17 before "denote."

18 DR. MYKLEBUST: Then we are back in the vague thing.

19 DR. HATLEN: Wide open.

20 DR. MYKLEBUST: You have nothing now.

21 Now, we have a little difficulty. Do you want to

22 talk about it over lunch? We have a little difficulty with

23 some of these. Do you want to be back at one o'clock to get

24 through earlier?

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25 (DISCUSSION OFF THE RECORD.)

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DR. MYKLEBUST: I must tell you we started at eight o'clock in order to speed up. The schedule was to go until five. Obviously that brings us up to four o'clock. Now, is there anyone who has to leave before four?

DR. HEWETT: It would help me if I could catch the 3:45 limousine.

(Discussion off the record concerning arrangements.)

DR. MYKLEBUST: If we terminate at three o'clock, you could make it. I'm inclined to think we will accomplish everything we can with this within two hours -- that is, from one to three this afternoon -- and then we will terminate.

All right. Is that agreed?

All right.

(Whereupon, at 12:05 p.m., the luncheon recess was taken.)

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1 A F T E R N O O N S E S S I O N

2 1:15 p.m.

3 DR. MYKLEBUST: Our procedure in the little time that
4 remains will, as much as we can, be as follows: We need a few
5 minutes -- and I would really like to limit it to a few minutes
6 because we do have another consideration that needs discussion
7 before we terminate today -- but we need to clean up a little
8 the term "intellectual," because I think three or four of you
9 have raised questions about its suitability for the purpose
10 here.

11 Now, the alternative was "mental retardation." Harrie
12 felt it limiting. Bill Heller felt it limiting. Some of you
13 feel that "intellectual" is a term which now doesn't really
14 cover what we mean here.

15 And if I should take a position, I can see your point,
16 and I suppose it does not mean really -- except as we read
17 into it -- what was intended here.

18 The intention I believe was that this would be the
19 problem of mental retardation along with other aspects.

20 So I must call your attention again to this fact --
21 that "intellectual impairment" is being questioned as not
22 meaning mental retardation, not even including it or implying
23 it to some of you.

24 Now, is there -- may I qualify -- serious objection

25 to putting "mental retardation" back in? "Emotional disturbanc

1 learning disability, mental retardation, sensory or motor
2 impairment"?
3 DR. BLAIR: I guess the area that concerned these
4 gentlemen was, of course, the area that doesn't fall within
5 limits and doesn't fall within the retarded area. This would
6 be the gray area between the educable and the normal. And I
7 think, Bill, you were speaking to --
8 DR. MYKLEBUST: Now we get into the problem of defin-
9 ing mental retardation. In the little writeup I sent you I
10 did specify that they would fall from 90 IQ and down, including
11 this slow learning. So slow learning here would be included
12 under mental retardation as intended.
13 MISS TAYLOR: However, that is not what most persons
14 think of under that.
15 DR. MYKLEBUST: Jo, I'm afraid that's right. I sup-
16 pose most people today I would guess would mean trainable. Cer-
17 tainly a lot of them do.
18 We have limitations on each term here. I don't think
19 there is an ideal solution for us. I think perhaps we have
20 to take the one we think does best for the purpose.
21 Yes, Bob?
22 DR. RIDGWAY: In terms of the intent of Congress, and
23 so on, in setting up these laws, if we had a youngster who
24 let's say was deaf and was a marginal case of mental retarda-
25 tion, theoretically this is a person who would not be eligible

1 for care in a mental retardation program. But I think if we
2 used the term "mentally retarded" here qualified as you used it,
3 it wouldn't bother anybody, because we are saying that combina-
4 tions of handicaps and their interactions are the things that
5 give us problems.

6 DR. MYKLEBUST: Right. Yes. And the next concern
7 now, if I could just structure a bit, because our next question
8 will be interaction-- There is some need to look at these in
9 terms of "different from services," "different from," because of
10 interaction. And we will come to that as soon as we clean
11 up this terminology a little bit more.

12 I do remind you I don't think we are going to be
13 able to get terminology here that is ideal or that suits all
14 purposes. We are going to have to use what we think is best
15 and then leave it there.

16 I don't want to, you know, ask each of us for a com-
17 mitment here. But let's ask again: Is there any serious ob-
18 jection to "mental retardation" there after "learning dis-
19 ability"? Is there anyone who is very unhappy with that?

20 DR. SELZNICK: I think you have to define the pur-
21 poses for arriving at a definition. If it's for immediate
22 purposes, for present purposes, I think "mental retardation"
23 is all right.

24 DR. MYKLEBUST: I see.

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25 DR. SELZNICK: If you're thinking of trends and

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directions which you think the field should take, well, then, I would be uncomfortable with it.

So I think purposes determine, actually.

DR. MYKLEBUST: Well, I will try to interpret and infer from our discussions, Harrie. I think what we have been doing has been staying with the basic categories and classifications rather than trying to establish new ones. And it is then likely that in the future this would have to be modified as the trend comes along perhaps in other ways too, Harrie.

It seems to me our purpose now is fairly immediate -- in other words, using that which is most generally used -- and "used" is very redundant here -- but is most generally followed at this time. Is that what we have been doing?

DR. WOLFE: Yet, Mike, when you say the specific category of mental retardation, you are not doing that for othe[r] specific categories like the deaf and the blind and the cerebra[l] palsied and all this.

As it is now, that term is somewhat comparable to the others. It is an intellectual deficit, a sensory deficit, a motor deficit.

DR. MYKLEBUST: Well, actually you're right. We are mixing terms. Learning disability is only that area, you see.

DR. WOLFE: That's right.

DR. MYKLEBUST: Now, in sensory we are including all of the sensory, auditory and visual.

1 DR. WOLFE: I know.

2 DR. MYKLEBUST: Instead of because we have a term.
3 In motor we are including all of those.

4 DR. WOLFE: I know.

5 DR. MYKLEBUST: So we have some specific and generic
6 terms here.

7 DR. HELLER: Well, I think the most commonly accepted
8 definition utilized is Heber's where he says mental retardation
9 refers to sub-average general intellectual functioning.

10 Now, if we use "mental retardation," and with the
11 implications you made that you are talking about a child with
12 below average, average being 90, then I would accept it.
13 Actually, using "mental retardation" doesn't bother me that
14 much, because it gives me the identity and the vision, whatever
15 I want here, from my angle.

16 But I am concerned then about the child who is 85
17 who certainly is a slow learner in the State of Illinois, for
18 example, who would not be multiply-handicapped under this
19 definition, who has also, let's say, a deficit in hearing.
20 What happens to him then?

21 DR. MYKLEBUST: You mean because we are using the
22 term "mental retardation" he wouldn't be included?

23 DR. HELLER: Here in the State of Illinois he wouldn't.
24 We are saying that he has to have two or more.

25 DR. MYKLEBUST: No, he wouldn't be a multiply-

1 handicapped unless he has more than an 85 level of intelligence
2 problem, no. That's right. But neither would anyone else.
3 DR. HELLER: No, I'm saying he isn't really mentally
4 retarded.
5 DR. MYKLEBUST: So you are saying the term "mental
6 retardation" wouldn't include this chap in Illinois?
7 DR. HELLER: That's right.
8 DR. MYKLEBUST: This is the problem, of course.
9 DR. HELLER: Even though the combination-- He certain-
10 ly needs a different type of program, you see.
11 DR. MYKLEBUST: This is the problem.
12 DR. ASHCROFT: Couldn't he get it through the hearing
13 handicap program, program for the hearing handicapped?
14 DR. HELLER: Well, they haven't settled on that issue
15 here in this particular State. In most States I think this is
16 true too, as far as hearing, partially hearing, or whatever.
17 I don't think he would get it in the deaf programs here in the
18 State of Illinois or most States.
19 DR. MYKLEBUST: He'd be picked up through it if he
20 has deafness or visual impairment and would be classified, yes.
21 DR. HELLER: But the complementary treatment here, the
22 concomitant action we are talking about with other services,
23 would not likely be made available.
24 DR. MYKLEBUST: Well, I can't comment on that. It
25 probably wouldn't be made available in lots of States. We

1 are trying to show how it should be.

2 DR. HELLER: But the semantic problem here doesn't

3 bother me. We go by "mental retardation" in the Office.

4 DR. MYKLEBUST: All right. Very good. Do you then

5 prefer the term "mental retardation"?

6 DR. DENO: I don't "prefer" it.

7 DR. MYKLEBUST: What?

8 DR. DENO: I don't "prefer" it. You know. It just

9 falls within the purview of what we are doing.

10 DR. MYKLEBUST: All right. Is it better? Jim, you

11 have problems with the other one.

12 DR. CHALFANT: Yes. I have fewer problems with

13 "mental retardation" than I do with the "intellectual" term.

14 DR. MYKLEBUST: All right. Frank Hewett? All right?

15 DR. HEWETT: I would agree, yes.

16 DR. MYKLEBUST: If we are satisfied then, despite the

17 limitations of the term, this will then read: "'Combinations

18 of handicaps' denotes two or more of the following: emotional

19 disturbance, learning disability, mental retardation, sensory

20 or motor impairment."

21 Now, then, if this is agreeable, I should like to

22 move on to the next part of the elaboration or clarification

23 that we need here.

24 Now, I'm going by what I think some of you have been

25 saying. And Corrine and I have been asking each other: Isn't

1 there a need to say something similar to clarify-- I'm trying
2 to get at what we now don't have. That is, that is this busi-
3 ness of "it's not additive," to try to spell out what "differ-
4 ent" means. It's not just adding them up.
5 We used the term "unique." We used the term "addi-
6 tive." It's not additive. And I thought a sentence or two
7 about what we mean as special education services that are dif-
8 ferent because of the interaction and the type of imposition
9 on development and learning that ensues-- What do you think?
10 Could we take that for a bit?
11 I think the more creative aspect of this multiple
12 handicap definition is this: Let's say that it seems to me in
13 a way most of us, including ourselves, look at this in terms
14 of deaf and retarded, deaf and blind, not something which
15 develops as a different type of learning disability but diff-
16 erent psychology of learning, imposition on learning. Can we
17 say something here that would help educators recognize that we
18 should no longer view this either in training of personnel or
19 very precisely in terms of proper programming for the child to
20 just talk in terms or think in terms of adding one, two, and
21 three?
22 Now, we get to core curricula, courses which then are
23 designed to cover the ways in which psychology of learning is
24 modified by the interacting processes, interacting impositions.
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25 Bob?

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1 DR. RIDGWAY: I was thinking that maybe we had three
2 terms left that we need to work on. One of them is the inter-
3 action business. Another is "special education service." And
4 another one might be this one that you have just mentioned.
5 In the interest of getting things moving rapidly --
6 DR. MYKLEBUST: Go ahead.
7 DR. RIDGWAY: -- I was wondering if we could split
8 up into about three groups and each group take one of those and
9 spend five minutes trying to get a statement down that we could
10 then work on, and then all come back together, and we would
11 have a running start on those three statements.
12 DR. MYKLEBUST: I think this is very good. Would you
13 on this side (indicating Miss Taylor, Dr. Selznick and Dr. Ash-
14 croft) take "interaction"? Is that all right?
15 DR. RIDGWAY: Corrine should be in that group.
16 DR. MYKLEBUST: Corrine, you take "interaction" with
17 these three people.
18 We have four there (indicating Drs. Chalfant, Ridgway,
19 Heller, and Wolfe). Will you take "special education services"?
20 What is the third one, Bob?
21 DR. RIDGWAY: The one you just mentioned.
22 MISS TAYLOR: "Different."
23 DR. RIDGWAY: "Different from." That it's not addi-
24 tive.
25 DR. MYKLEBUST: That's right. Take "special

1 education services" back there, please.

2 Will you take the uniqueness, different from any

3 single or added one or two deficits (indicating Drs. Hatlen,

4 Blair, Deno, and Hewett)?

5 (The Conference divided itself into subcommittees.)

6 DR. MYKLEBUST: Now, I think the sequence is to start

7 here, as I recall. You are the ones involved with "inter-

8 action," aren't you?

9 DR. KASS: All right.

10 DR. MYKLEBUST: First we have the term "interaction."

11 All right.

12 DR. KASS: "Interaction" refers to the correlation of

13 deficits which results in behavior not characteristic of chil-

14 dren with single handicaps.

15 Correlation of deficits which result in behavior not

16 characteristic of children with single handicaps.

17 DR. HEWETT: "Correlation" just doesn't compute. It's

18 the only word there.

19 DR. KASS: Shall I read the other one?

20 DR. MYKLEBUST: Yes, let's have all of them.

21 DR. KASS: "Interaction" involves the process by

22 which the combination of handicaps produces an aggregate of

23 adaptive characteristics which may not be present in each

24 single handicap.

25 DR. MYKLEBUST: Any more, Corrine?

1 DR. KASS: No, that's it.

2 DR. WOLFE: We'll have to define the words now that
3 you used and have sentences which define the words that were
4 used.

5 DR. KASS: We could say "produces the adaptive char-
6 acteristics." Never mind the "correlation."

7 DR. WOLFE: What do you mean by "adaptive character-
8 istics"?

9 DR. KASS: Well, an example would be in the case of
10 a deaf blind person who would not be able to use the other
11 sense organ in compensation or as --

12 DR. WOLFE: Are you going to be there to read it to
13 the person who should know it?

14 DR. KASS: No.

15 MISS TAYLOR: I wonder why we need to have the defi-
16 nition of the word "interaction"?

17 DR. MYKLEBUST: Now, this is a possibility I think.
18 May I suggest, just to see where we are standing here-- Maybe
19 we can combine again. We have heard this committee's suggestion
20 I'd like to hear the others. It would help us I believe to
21 take the whole.

22 Could we have the one down here which deals with
23 special education services? Who has it?

24 DR. RIDGWAY: "Special education services" include
25 provisions for identification and evaluation, placement,

1 instruction, and rehabilitation of children who cannot profit
2 from the program offered in the typical school situation.
3 DR. MYKLEBUST: All right. Once more.
4 DR. RIDGWAY: "Special education services" include
5 provisions for identification and evaluation, placement, in-
6 struction, and rehabilitation of children who cannot profit
7 from the program offered in a typical school situation.
8 DR. DENO: From the special education program offered
9 in the typical school situation.
10 DR. MYKLEBUST: Go ahead, Bob.
11 DR.RIDGWAY: In this instance, "special education
12 services" has to refer to general special education services,
13 and then you are going to talk about why these aren't enough.
14 DR. DENO: Oh.
15 DR. RIDGWAY: For these kids.
16 DR. HEWETT: Is "rehabilitation" correct?
17 DR. WOLFE: It's "habilitation."
18 DR. HEWETT: It's "habilitation" much of the time,
19 isn't it?
20 DR. MYKLEBUST: You get into a lot of trouble with
21 that. Some of your more pure purists will point out to you,
22 and quite rightly, that you can't find "habilitative" in the
23 dictionary. But it is used a great deal. But really, accord-
24 ing to I believe most excellent dictionaries -- we have been

25 through this many times -- I believe you will find there is no

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1 such word. It is still used particularly I find in the field
2 of speech correction.
3 As a matter of fact, we have on the books I believe in
4 our bulletin a title of a course which uses the term. Don't
5 ask me to report the hassle the faculty went through. Because
6 apparently there is no such word at all. The man who was
7 really defending this is an excellent dean in the sense of
8 words and language, and it was extremely difficult for him to
9 take. And I really couldn't blame him.
10 Now, any other suggestions down here? You have said
11 what you have? You have given us your suggestion?
12 DR. RIDGWAY: We were not certain how to work "medi-
13 cal processes" into this, and before anybody jumps on us, the
14 example that was used was an epileptic youngster who might be
15 on drugs.
16 DR. MYKLEBUST: Yes, but these wouldn't be special
17 education services, would they?
18 DR. HEWETT: Ancillary.
19 DR. MYKLEBUST: They are ancillary. I think we are
20 holding to special education services here.
21 Now, then, the "different" idea here, the unique part
22 of it. Who has that?
23 DR. BLAIR: All we did was identify three items. We
24 did not combine them into a statement. But we were talking
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25 in terms of variations in traditional program organization for

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these children, innovations in methodologies -- in other words, qualitative differences from what we now have.

This is a little awkwardly stated, but teachers whose training reflects concern for the combinatory influence of the handicaps involved.

DR. MYKLEBUST: What kind of influence?

DR. BLAIR: Combinatory.

DR. MYKLEBUST: I'll have to get my dictionary.

(Laughter)

DR. BLAIR: It's in the dictionary.

DR. WOLFE: It is?

DR. BLAIR: Oh, yes.

DR. HELLER: Maybe we'd be better off if we stayed with our definition.

DR. WOLFE: I never heard that word. I'm sorry.

DR. MYKLEBUST: I never have either.

DR. SELZNICK: What does it mean?

DR. BLAIR: We can say "combinations."

DR. MYKLEBUST: Combinations of.

DR. BLAIR: "Combined" I'm sure would be --

MISS TAYLOR: Would you spell that word?

DR. BLAIR: Let's drop it. (Laughter)

DR. MYKLEBUST: I think we have Frank back against the wall. He has withdrawn. He doesn't have his dictionary in his pocket. (Laughter)

1 Jo raised an excellent question here a while ago. I
2 had no idea. And I should have anticipated it. Because it's
3 very obvious that we should have had a set of dictionaries
4 around here.
5 DR. WOLFE: A thesaurus.
6 DR. MYKLEBUST: I didn't really think of it.
7 Now, we have the suggestions before us.
8 DR. WOLFE: Is he through? I'm sure there is more
9 after "combinatory." (Laughter)
10 DR. MYKLEBUST: Are you through, Frank?
11 DR. BLAIR: I think so. I feel as though I am.
12 (Laughter)
13 DR. WOLFE: You had three I thought. That was only
14 one. I think we have a minority report.
15 Phil, go ahead.
16 DR. HATLEN: I tried in an awkward way to put some
17 of this together, and I got "different from those required"
18 refers to the need of multiple handicapped children for unique
19 services not traditionally offered for singly-handicapped
20 children. In some cases a combination of several services,
21 each specific to a single handicap, may meet the educational
22 needs of multiple handicapped children. In other cases new
23 and innovative educational planning is required.
24 And I wouldn't want to spell out "new and innovative
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22 needs of multiple handicapped children. In other cases new
23 and innovative educational planning is required.
24 And I wouldn't want to spell out "new and innovative
25 educational planning" anymore, because I don't think we know.

1 DR. BLAIR: "New and innovative" is redundant. I'm
2 going to pick on you. (Laughter)
3 DR. HATLEN: Okay.
4 MISS TAYLOR: Besides, if you put it down it won't be
5 new.
6 DR. MYKLEBUST: I would like to take Jo's question
7 now for all of us. It seems to me maybe I was imposing a bit
8 here when I suggested that we needed to do this. Jo raises the
9 question-- Let's take their area first. We really must take
10 all of them, but we'll take theirs first. Do we need to spell
11 out "interaction"? Is it clear enough? Is it better without
12 spelling it out?
13 DR. HEWETT: There is no way really to define it
14 without getting awfully abstract and kind of loose I think here.
15 DR. MYKLEBUST: I think you're right. And I think if
16 there is any rule of thumb which could be applied it is that
17 sometimes spelling out is really where you bring in trouble.
18 It's much more useful to more people sometimes if
19 we don't spell out too much.
20 DR. SELZNICK: Yes.
21 DR. MYKLEBUST: Now, I want to sort of get some
22 representative opinion. Corrine, how do you feel about it now?
23 Do you feel that "interaction"could be left?
24 DR. KASS: Yes, I would very much like that.

25 DR. MYKLEBUST: I think giving thought to it and seei

1 what it does is one way to decide not to do it, you see.

2 I think the point, the question, is very well taken

3 that we might not spell out "interaction" but leave it for the

4 manifest meaning that it has.

5 Evelyn, comments?

6 DR. DENO: No. That's all right.

7 DR. MYKLEBUST: Frank?

8 DR. BLAIR: It sounds good.

9 DR. HEWETT: Yes.

10 DR. MYKLEBUST: Nice work, Committee. (Laughter)

11 DR. SELZNICK: We "interacted" in order to come to

12 that conclusion.

13 DR. HEWETT: Twice more and we'll be home free.

14 (Laughter)

15 DR. MYKLEBUST: We'll apply this question to the

16 others after this. After this consideration, what do you think

17 about "special education services"? Do you want to spell it

18 out?

19 Jim?

20 DR. CHALFANT: Well, something that happened here--

21 We all sat down and started writing things down in the way

22 of services and came up with basically the same list. There

23 were a few differences.

24 DR. MYKLEBUST: Well, there is validity in this

25 process, you know, Jim.

1 DR. CHALFANT: And I think that's probably more con-
2 crete than "interaction," so I wouldn't be upset with not defin-
3 ing "special education services," although I like what we have.
4 DR. MYKLEBUST: Could we hear it again now, please?
5 DR. RIDGWAY: "Special education services" include
6 provisions for identification and evaluation, placement, instruc-
7 tion, and rehabilitation of children, and so on.
8 DR. MYKLEBUST: Now, let's assume that is just up here
9 now as further clarification of the definition. How do you feel
10 about it? Does it add to it?
11 DR. DENO: I don't think it adds anything that any-
12 body couldn't have defined, anybody in special education
13 services.
14 DR. RIDGWAY: I think the only reason the matter came
15 up at all was that there was question whether "services" was
16 the proper word. And when we decided that "services" was
17 more inclusive and included all these other things, then maybe
18 we don't need it.
19 DR. MYKLEBUST: It is the result probably of a
20 compulsive chairman who is trying to see we get these words
21 out, so I am imposing some of this I am afraid.
22 DR. SELZNICK: Just to raise a question, I think we
23 have to look at who is going to use this upon completion. Now,
24 people with orientation in special education all came to the

25 basic conclusion. If legislators are going to look at it, do

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1 they need a spelling out?

2 DR. WOLFE: They have spelled it out in their legis-

3 lation.

4 DR. MYKLEBUST: Yes, but let's take the question

5 now this way too, Bill. Because I think we agree there is a

6 tremendous need in organizations like ACLD and many others to

7 know precisely what we mean. And I have a feeling that it could

8 be something that we are missing if we don't sort of tell them

9 a little more about what we mean here in connection with this

10 definition.

11 Go ahead, Frank.

12 DR. HEWETT: Can't we combine these two then? I think

13 that is the logical thing to do.

14 DR. MYKLEBUST: Let's see how that goes then. Fine.

15 Let's see how it goes.

16 Now, what is your list here, Committee 3?

17 DR. BLAIR: We have "combinatory." (Laughter)

18 DR. MYKLEBUST: You're going to combine the combina-

19 tories? (Laughter)

20 DR. BLAIR: Obviously we think ours is the most import-

21 ant of the three. (Laughter)

22 Variations in traditional program organization.

23 DR. DENO: Put them together with services in differ-

24 ent ways than we conventionally do it.

25 DR. MYKLEBUST: I think that's important here. I think

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1 this is really the creative aspect of the implications, isn't
2 it?
3 DR. BLAIR: Yes, I think so.
4 DR. HEWETT: Variations and innovations related to --
5 DR. BLAIR: It seems to me the combinations of handi-
6 caps, the combinatory influence, must have innovative method-
7 ologies. It seems to me this is --
8 DR. DENO: There is a second one though.
9 DR. BLAIR: Yes.
10 DR. DENO: That is the one he is talking about where
11 the combination of handicaps produces results for which you
12 must apply different technology, not pulling together the ones
13 that already exist somewhere in the roster that you have got
14 in your cafeteria or whatever.
15 DR. MYKLEBUST: Bill?
16 DR. WOLFE: Try this: These services represent
17 individual and unique programming and are not the sum of
18 approaches commonly used with separate or individual problems.
19 Isn't that what we're talking about?
20 DR. MYKLEBUST: I think that's what we are talking
21 about -- separate or individual handicaps.
22 DR. WOLFE: Or handicaps.
23 MISS TAYLOR: Read the whole thing.
24 DR. BLAIR: I just now repeated only two of them.

25 The third one is what I am concerned about, and that is that

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1 our professional preparation must take into account-- If we
2 are going to train teachers of the multiply-handicapped, we
3 have to take into account --
4 DR. MYKLEBUST: But, Frank, I think this is a sen-
5 tence that could, if you want to draw this implication for
6 people-- It's a sentence you can add. You can add the sen-
7 tence that this has implications for training, you see.
8 DR. BLAIR: Yes.
9 DR. MYKLEBUST: And it might be that we want to add
10 such a sentence to get the implication right now.
11 Evelyn?
12 DR. DENO: You could state this almost so that it is
13 parallel, and then the implication for training is there.
14 That is, one was that you needed to combine the kind of services
15 which you already offer in ways which are unique to this, which
16 are created uniquely by this combination of handicaps. And
17 the second is that for some kind of cases there may be innova-
18 tions in methodology which have to be made because the combina-
19 tion produces a qualitatively different consequence.
20 And then the third one is that the people working
21 with these children must understand the effects of the combina-
22 tion of handicap so that they apply the principle properly.
23 DR. MYKLEBUST: I think just such discussion -- which,
24 fortunately, will be available to us in the transcript all the
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25 way through -- will be exceedingly helpful after this, even

1 though we want to try to get as much of it said in this form
2 today as possible.
3 But these discussions like this I think will be very
4 useful to us on a long-time basis because it will be available.
5 I think then that we're all saying that we feel this
6 is an exceedingly important aspect of the area of multiple in-
7 volvement. If I may, I should like to ask Bill Wolfe to read
8 his again for your consideration.
9 DR. WOLFE: These services represent specific and
10 unique programming and are not the sum of approaches commonly
11 used with separate or individual handicaps.
12 DR. MYKLEBUST: All right. Now, does that incorpor-
13 ate what you had over here?
14 DR. BLAIR: It is not explicit I think in terms of
15 innovative methodologies, is it? Did I miss that?
16 DR. WOLFE: I said we could use innovative methodolo-
17 gies. I said "specific and unique programming."
18 DR. MYKLEBUST: Specific and -- ?
19 DR. WOLFE: And unique programming.
20 DR. BLAIR: The word "programming" gave us trouble
21 before.
22 DR. MYKLEBUST: Specific and unique methodologies.
23 DR. WOLFE: Fine.
24 DR. MYKLEBUST: Is it better?

25 DR. HEWETT: You would precede that with your listing

1 of the characteristics of services. Was that the-- You would
2 exclude your listing of the categories of service?
3 DR. MYKLEBUST: I was assuming they would be ex-
4 cluded. We felt they were redundant.
5 Bob?
6 DR. RIDGWAY: There are two meanings to me at least
7 for the word "programming" -- one, the red flag one that has
8 been bothering people, and the other the more inclusive term
9 that encompasses all the things that you do for a youngster
10 from the time --
11 DR. MYKLEBUST: But it is a hard term to handle. I
12 think we have been through that.
13 DR. WOLFE: We are going to use "methodologies."
14 DR. RIDGWAY: Maybe "methodology" doesn't get at all
15 the things that are involved in the second definition of
16 "program."
17 DR. WOLFE: Approaches.
18 DR. BLAIR: Bill, could you put that on the board so
19 we could see that?
20 DR. WOLFE: Harrie, do you want to do that? I can't
21 write. (Laughter)
22 DR. MYKLEBUST: Bill Heller, can you write? I see
23 we have to get out our written language tests and see who quali-
24 fies. (Laughter)
25 DR. WOLFE: I can't write on the board.

DR. MYKLEBUST: Evelyn?

DR. DENO: Bill, when you say "programming" or "methodology," does that include people to you? Because I think it is important that the teachers, the psychologists, the people working --

DR. WOLFE: The programming would. The methodologies would not.

DR. DENO: I think it is important that the people managing the learning experience of these children understand the effect of this.

DR. WOLFE: I think that's a good point.

DR. DENO: And that should be in there.

DR. WOLFE: "Programming" would I think include people. "Methodologies" would not, as I see it.

DR. MYKLEBUST: I doubt it.

DR. HEWETT: "Planning" wouldn't do it.

DR. MYKLEBUST: I was wondering. Would "planning" do it?

DR. RIDGWAY: How about "programs and methodologies"? Use two words.

DR. MYKLEBUST: Yes.

MISS TAYLOR: I believe that our definition this morning was so clear and so succinct that anything we are adding this afternoon is making it more confusing and limiting rather than giving opportunity for expansion by innovative

1 people.

2 DR. MYKLEBUST: Jo, are you including in that this

3 "combination of handicaps denotes" part of it? You would leave

4 that, wouldn't you? Just this afternoon's discussion?

5 MISS TAYLOR: I believe that that combination is

6 good. What we did this morning I think is adequate.

7 DR. MYKLEBUST: Yes, I thought that's what you meant.

8 Just this afternoon's then.

9 This question we will raise again as soon as we see

10 this up here.

11 DR. HELLER: Is that plural or singular on the end,

12 Bill?

13 DR. WOLFE: Singular.

14 DR. MYKLEBUST: It was meant to have two words I

15 think. "These services represent specific and unique programs

16 and methodologies." Am I right? Is that what we said?

17 DR. WOLFE: What Bob said, yes.

18 DR. MYKLEBUST: Programs and methodologies. Now I

19 think we have it. Unique programs and methodologies. And are

20 not the sum of approaches commonly used with separate or

21 individual handicaps.

22 DR. HEWETT: "Include" is better than "represent"

23 isn't it?

24 DR. BLAIR: I think it would be.

25 DR. MYKLEBUST: Include.

ERIC

1 DR. SELZNICK: Yes.

2 DR. MYKLEBUST: All right. Change "represent" to
3 "include."

4 MISS TAYLOR: I hope that they won't misunderstand and
5 think that by "unique programs" -- that they will not feel it
6 has to be a separate place.

7 DR. BLAIR: Yes. We had the word "innovative" in
8 here, which I still like very much, and I wonder if perhaps that
9 shouldn't be substituted.

10 DR. MYKLEBUST: Instead of "unique"?

11 DR. BLAIR: Instead of "unique."

12 DR. HEWETT: Doesn't "innovative" kind of denote --

13 DR. WOLFE: Experimental.

14 DR. HEWETT: -- an experimental kind of thing? You
15 know. Somebody might say, "Well, I could come up with a unique
16 program. I don't know whether I could come up with an inno-
17 vative program." The criterion of more creative --

18 DR. BLAIR: Aren't we really trying to lead the way
19 here a bit? I think we are suggesting we need a new approach.

20 DR. MYKLEBUST: We are trying to lead the way.

21 I would like to raise the question this way: "These
22 services include specific programs and methodologies which are
23 not"-- Leave out this (indicating) and not put a qualifier in
24 there at all. ". . . include specific programs and methodologies
25 which are not the sum of approaches commonly used."

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1 You see, you are saying it down below. They are not
2 additive. They are not the sum of, and so on.
3 If this word is troublesome up here, if "innovative"
4 and "unique", and so on, are troublesome, you have a good state-
5 ment without either word there, don't you, Harry?
6 DR. SELZNICK: I don't like the word "innovative" per-
7 sonally under any circumstances.
8 DR. MYKLEBUST: Well, "unique" is a little difficult
9 too, I suppose.
10 Corrine?
11 DR. KASS: I feel this statement is merely restating
12 "special education services different from," which is quite
13 a clear statement.
14 DR. HEWETT: We are merely saying --
15 DR. KASS: We are saying here "unique and innovative"
16 now instead of "different from."
17 DR. MYKLEBUST: We are trying to say why they are
18 different. That's right. All right. Then, if --
19 DR. RIDGWAY: Do you need "specific" in there?
20 DR. MYKLEBUST: I think it's better without "specific"
21 if we use the statement, I really do. These services include
22 programs. Let's leave it out.
23 Now, however, some of us have a feeling that we don't
24 need this at all. Are we better off without it? Bob, what

25 would you do?

1 DR. RIDGWAY: Sam's point this morning I thought was
2 a very valid one -- that we need to indicate that there is
3 something different here. I think we need to spell it out
4 more carefully here than we did in the first sentence to indi-
5 cate that you don't add up a blind program and a deaf program
6 to take care of it.
7 DR. MYKLEBUST: Yes, that has been very much stressed,
8 and I would like this to come through for us.
9 Phil, you felt that all along?
10 DR. HATLEN: Yes. I think though this statement
11 doesn't cover one area which I don't want to see left out,
12 either, and that's the situations in which two services for
13 singly-handicapped children can combine to serve a child.
14 I'm thinking of, for example, a mentally retarded
15 visually handicapped child who is placed in one or the other
16 program with an itinerant teacher serving him, and this works
17 out quite satisfactorily in most cases, and I don't see the
18 necessity for something different in that case.
19 DR. RIDGWAY: "Not necessarily."
20 DR. MYKLEBUST: Bob says to meet this we say "not
21 necessarily." Does that help, Phil?
22 DR. HATLEN: All right.
23 DR. HEWETT: Can't we put that whole statement,
24 "Special education services different from those required
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25 for children with a single handicap include programs and

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1 methodologies which are not the sum of approaches," and then
2 kind of wind that up in some way? Because I think we have
3 to be consistent if we are going to pull out from the main
4 definition. In other words, we are going to have to take that
5 whole phrase, aren't we, Corrine, out of there and then try to
6 work it in?

7 "These services" is too abrupt.

8 DR. MYKLEBUST: That's right.

9 DR. HEWETT: That means we have to patch up the end
10 of it somehow so it is not too redundant.

11 DR. HEWETT: Don't you really have "special education
12 services different from those required for children with a
13 single handicap" underlined?

14 DR. ASHCROFT: Say "different special educational
15 services."

16 DR. RIDGWAY: We wouldn't have to use the exact
17 phraseology.

18 DR. MYKLEBUST: Special education services include.
19 All right?

20 DR. BLAIR: Well, I think the meaning --

21 DR. MYKLEBUST: It isn't what we were doing before.
22 We were taking out-- You see, this should be somewhat con-
23 sistent in format. Editorially it is desirable, of course.
24 So why not just do it the simple way. Take "special education
25 services."

ERIC

1 DR. BLAIR: Refer to.

2 DR. HEWETT: We could say "in ways which require
3 different education services" up in the main thing and then put
4 the comparative down below.

5 DR. MYKLEBUST: I didn't follow that. I see now. We
6 would have to take that whole last part, "special education
7 services different from those required for children with a
8 single handicap" include.

9 DR. KASS: Why couldn't we add part of this to the
10 sentence which is not too long to begin with. Say "special
11 education services which are not necessarily the sum of
12 approaches commonly used."

13 DR. HEWETT: Different from and not necessarily --

14 DR. KASS: Different from and not necessarily the sum
15 of approaches -- the sum of something -- required for children
16 with a single handicap.

17 DR. CHALFANT: Then you are defining in a positive
18 and a negative way in the same sentence. It's very easy to
19 grasp that first sentence right now.

20 DR. MYKLEBUST: The first sentence is really worked
21 out very, very well. It is really hammered out beautifully.
22 It is possible that we could put some of it up there. But
23 we already have a format precedent where we are doing this.

24 So we could just go ahead and put this "special
25 education services different from those required for children

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1 with a single handicap." We'd have to repeat this.

2 DR. KASS: The whole thing.

3 DR. MYKLEBUST: Then "include." Wouldn't we?

4 DR. CHALFANT: I'm not sure if we would or not.

5 DR. MYKLEBUST: Where would you cut it, Jim?

6 DR. CHALFANT: Could you say, "By 'special education

7 services which are different' we mean" -- or "is meant" --

8 this other idea? That way you wouldn't have to reproduce

9 three-fourths of the original definition.

10 DR. MYKLEBUST: Well, otherwise I think we had the

11 suggestion that "different special education services include."

12 DR. CHALFANT: Yes.

13 DR. BLAIR: I think that changes the meaning a bit.

14 DR. MYKLEBUST: Yes, it does.

15 DR. BLAIR: When you put "different" at that point.

16 DR. MYKLEBUST: Yes, it does.

17 DR. CHALFANT: Which are different.

18 DR. RIDGWAY: How much would we hurt the simplicity

19 of the first sentence if right after "different from" we said

20 "and not necessarily the sum of approaches used or approaches

21 commonly used with children with separate or individual

22 handicaps"?

23 DR. KASS: Required for children --

24 DR. HEWETT: You could add a sentence and say, "Such

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25 services are not necessarily the sum. . ." In other words, you

1 can add it as a final sentence there. "Such services are not
2 necessarily the sum of approaches commonly used with such chil-
3 dren."
4 DR. MYKLEBUST: I think this is a real possibility.
5 Any other reactions as you see it there? That simplifies it?
6 Don't you think?
7 DR. RIDGWAY: Instead of "approaches," we can put
8 "programs and methodologies" in up there and move right ahead.
9 DR. MYKLEBUST: Right.
10 DR. BLAIR: That may do it.
11 DR. MYKLEBUST: Do we have it all up there?
12 DR. KASS: I didn't catch that. Such services are
13 not necessarily the --
14 DR. RIDGWAY: -- the sum of programs and methodologies
15 commonly used. And start with "which." Knock out the rest of
16 that. Knock out "which" also. And knock out "sum of approaches."
17 DR. HEWETT: Commonly used with these children. We
18 have got our reference of children. Can't we just say "these
19 children"?
20 DR. RIDGWAY: No, we don't have that part in there.
21 DR. HEWETT: Yes, we just said it -- required for
22 children with a single handicap. Doesn't that take us back to
23 children with a single handicap?
24 DR. RIDGWAY: You're right.

25 DR. MYKLEBUST: Yes.

1 DR. HEWETT: We can't say "such children."

2 "These services" might be better, and then "these

3 services are not necessarily with such children."

4 DR. KASS: Commonly used in special education?

5 DR. MYKLEBUST: Commonly-- Frank is getting at this.

6 Commonly used with children --

7 DR. HEWETT: I say "with such children," and put

8 "these services" to start that sentence. "These services are

9 not necessarily the sum of programs and methodologies commonly

10 used with such children."

11 DR. BLAIR: I think that's not going to be clear

12 enough, Frank. I think when you see it laid out there it won't

13 MISS TAYLOR: It goes back to the multiply-handicapped

14 DR. HEWETT: Singly-handicapped children.

15 DR. BLAIR: I think "such services" might be all right

16 but I think --

17 DR. MYKLEBUST: Those having individual handicaps.

18 DR. HEWETT: That would do it.

19 DR. BLAIR: Yes.

20 DR. MYKLEBUST: Commonly used with those having

21 individual handicaps. And then, Corrine, up there change

22 "these" back to "such."

23 DR. HEWETT: "Such" is a better introduction.

24 DR. MYKLEBUST: Now, Sam Ashcroft has something. Sam,

25 go ahead.

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1 DR. ASHCROFT: It's only a general observation. I
2 have been led to this every time we try to define a group. We
3 are so educationally oriented we want to educate society and
4 the profession and spell things out so that people can do them
5 by cookbook recipes.
6 DR. MYKLEBUST: Yes.
7 DR. ASHCROFT: I don't think we should have to do
8 that. Anyone who wants to provide services for multiple handi-
9 capped children shouldn't be in the business if he has to be
10 instructed by a definition.
11 DR. MYKLEBUST: Well, I think this, however, is simp-
12 ly saying what we mean in the definition by "special education
13 services." Now, that is the question again -- whether it is
14 really necessary.
15 DR. BLAIR: I don't think --
16 DR. MYKLEBUST: There seem to be both opinions, and
17 again I should think there is merit to both sides.
18 Yes, Frank?
19 DR. BLAIR: I was going to say it is partially a
20 mandate, but I don't think it is a prescription, Sam, for
21 precisely how this must be done.
22 DR. HATLEN: One other thing on this.
23 DR. MYKLEBUST: All right.
24 DR. HATLEN: As I understood it, when we were

25 breaking this sentence apart, "special education services" up to

1 that point -- and as this committee down here defined it --
2 referred to services as we know them in special education.
3 Now we are saying that such services-- The added
4 sentence is now referring to such services that are different,
5 isn't it?
6 DR. MYKLEBUST: Yes.
7 DR. HATLEN: So we can't use "such" necessarily, be-
8 cause that assumes we are referring back to the services in the
9 previous sentence, which wasn't meant to indicate the services
10 for multiply-handicapped.
11 DR. HEWETT: Such different services.
12 DR. MYKLEBUST: It's the different ones, though, Phil.
13 Special education services different from those. So I think
14 the "such" is a proper reference there.
15 DR. HEWETT: It takes us back to that whole phrase.
16 DR. MYKLEBUST: Yes.
17 DR. SELZNICK: Phil is suggesting it should be "such
18 different services." I think that's what Phil is suggesting.
19 DR. HATLEN: Yes. But if we look at that in its
20 entirety, it seems to go okay.
21 DR. MYKLEBUST: Yes.
22 DR. HATLEN: How about "single handicaps" instead of
23 "individual"?
24 DR. MYKLEBUST: "Single" is better I think.

25 DR. CHALFANT: If I didn't know very much about the

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1 special education and I looked at this, I would say, "Well,
2 what services are they talking about then?"
3 To me this sentence may very well raise questions in
4 people's minds as they read it. I think it raises more ques-
5 tions than it solves.
6 DR. HEWETT: We have to define "special education."
7 DR. CHALFANT: That's what we are doing.
8 DR. HEWETT: We're getting down to the kind of primer
9 level that Sam is mentioning here.
10 DR. MYKLEBUST: It seems to me, Jim, that it is
11 highly desirable that we not suggest or indicate exactly how
12 these are different. In the definition we are saying they
13 are not the sum of those which exist. Now, actually, what we
14 are doing as a conference is to suggest we need lots of
15 innovation. Something has to be done. And, believe me, so far
16 as I know, it isn't being done very much.
17 DR. CHALFANT: I'm not suggesting we try to spell it
18 out.
19 DR. MYKLEBUST: I think this is what we mean by this
20 additional statement.
21 DR. CHALFANT: The thing is a negative statement
22 never helps me very much, and it always raises questions in
23 my mind, and I am sure it will in others'.
24 I'm not suggesting that we go into any more detail.
25 I just don't think it adds a great deal.

ERIC

1 DR. DENO: Can I throw out a different statement and
2 see if it does anything for Jim?
3 DR. MYKLEBUST: Go ahead, Evelyn.
4 DR. DENO: I have a positive statement which includes
5 our three parameters. I wonder whether it did anything for you.
6 "Different special education services" may include
7 standard service components organized to produce a unique
8 impact, development of unusual services which -- well, I have
9 got something redundant in here -- which may need to be de-
10 veloped to accommodate to the distinct effect on learning
11 produced by the interaction of handicaps and staff trained to
12 understand the educational implications of interacting handi-
13 caps.
14 It is those three components again, putting them
15 positively.
16 MISS TAYLOR: May I ask a question?
17 DR. MYKLEBUST: Sure, Jo.
18 MISS TAYLOR: Who do we think is going to be reading
19 this who won't understand what we mean by the first two para-
20 graphs? And if we are thinking of legislators, haven't they
21 already passed a great deal of legislation pertaining to special
22 education and somehow must have gotten an idea of what it is
23 about? It seems to me so condescending, sort of arrogant to
24 be spelling this out to such a degree for people in the field.
25 And people outside of the field must have some --

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1 DR. MYKLEBUST: And still as a committee here we have
2 a very hard time saying it, a very difficult time.
3 DR. HEWETT: But there is I think a very desirable
4 sort of presentation of the need for innovation and some kind
5 of unique putting together of programs that is implied by that
6 last statement. It is sort of a challenge to the field: "Look,
7 just don't think 'different' means 'sum total.'"
8 DR. MYKLEBUST: That's right.
9 DR. HEWETT: It's the "you've got to pick the ball up
10 and do something" kind of thing.
11 DR. MYKLEBUST: This is precisely the way I feel
12 about it.
13 DR. HEWETT: It has a nice ring to it.
14 DR. MYKLEBUST: I really can't assume that teachers
15 or groups or training centers-- I think as a committee we
16 are not being arrogant. I think we are being realistic if we
17 assume that some challenge in this area would be helpful. I
18 really do.
19 DR. HEWETT: Because, you see, there really isn't
20 any precedent. We're not referring to a body of knowledge or
21 programming that is there. It has got to be developed in a
22 sense. We are just saying, "Go out and do something about it."
23 DR. MYKLEBUST: I think that's one of the great
24 virtues of the statement.
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25 Jim?

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1 DR. CHALFANT: Isn't the challenge in the phrase
2 "different from those required for children"?
3 DR. MYKLEBUST: Yes, but you spell it out so you tell
4 a little bit more about what you mean by the challenge. Differ-
5 ent alone doesn't do it for me. I think there is a lot left
6 out in "special education services different from."
7 What you have added here means a great deal more to
8 me. Not necessarily the sum of the programs, and so on.
9 We had that in, you know, this morning many different
10 ways. We don't just add this up and get a multiply-handicapped
11 program or services which are adequate to the multiply-handi-
12 capped child.
13 DR. BLAIR: Just one matter of refinement, and that
14 is whether we have in terms of paragraphing here put descrip-
15 tion of the services a little bit out of place.
16 Looking at our previous definition of yesterday, we
17 define things as they occurred in the definition. And, you see,
18 "combinations of handicaps" comes first and then "services."
19 For convenience we have brought "services" in right
20 following it in the original definition, which I think is
21 perhaps the more important of the considerations here. But
22 I'm just wondering in terms of polishing whether we need to --
23 DR. HEWETT: We could put in parentheses after
24 "combination of handicaps" that definition of two or more of
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25 the following with the colon.

1 DR. MYKLEBUST: You could.

2 DR. DENO: Put "combinations of handicaps" and then

3 followed by "such."

4 DR. MYKLEBUST: I like the way --

5 DR. BLAIR: I think it's in there, but I'm just talk-

6 ing about --

7 DR. MYKLEBUST: I think we've got it. You see, you

8 put parentheses-- Where was that, Frank?

9 DR. HEWETT: It might make it unwieldy, but after

10 "combinations of handicaps" put in the definition.

11 DR. MYKLEBUST: That's the idea.

12 DR. HEWETT: Then we keep our --

13 DR. MYKLEBUST: Two or more of the following. We

14 don't need "'combinations of handicaps' denotes." That's it.

15 DR. WOLFE: What in the world did you do? I can't

16 get there from here.

17 DR. HELLER: Read it now.

18 DR. KASS: "'Multiple handicap' refers to combina-

19 tions of handicaps (two or more of the following: emotional

20 disturbance, learning disability, mental retardation, sensory

21 or motor impairment) which interact to impede development and

22 learning in ways which require special education services

23 different from those required for children with a single

24 handicap. Such services are not necessarily the sum of programs

25 and methodologies commonly used with those having single

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1 handicaps."

2 DR. DENO: You can make it more challenging and go on

3 and say they call for innovation, and so on.

4 DR. HEWETT: Say "charge" -- with an exclamation

5 point. (Laughter)

6 DR. MYKLEBUST: Ladies and gentlemen, I think that is

7 a good statement. I think this is a very fine statement. And

8 we are up to two-thirty. I would like to sort of terminate the

9 discussion of this problem of multiple involvement.

10 I think the area of multiple handicap here certainly

11 from my point of view has been substantially clarified. And

12 I thought perhaps for just a few minutes before you want to

13 leave that we would have time to ask each other whatever few

14 questions we want to, perhaps as some of these things might

15 apply to us in our own programs.

16 Is there anything we want to ask? Does anyone have--

17 Yes, Bill?

18 DR. HELLER: I have a question.

19 DR. MYKLEBUST: Go ahead.

20 DR. HELLER: I suppose I could ask Corrine some day

21 at the office. But as an outsider in the field of learning

22 disability, how do you envision programs for these children

23 being set up in special classes and the number in classes and

24 how these will be staffed?

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25 Because I think when we think of a training program

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1 it isn't so much the individual program but how they are going
2 to be grouped to handle them. And I just wonder how this is
3 going to be done.

4 DR. MYKLEBUST: Well, in our own efforts, Bill, we
5 take learning disabilities on a continuum.

6 Now, as a general rule of thumb, we can say that the
7 receptive auditory involvement is the one that is the most
8 debilitating and the one that you see first. That is, you see
9 them in the younger children, preschool, early school life.
10 Because receptive auditory dysfunctions impede all "getting
11 along in school" kind of learning, you see.

12 DR. HELLER: Right.

13 DR. MYKLEBUST: So you see these early in life.

14 Incidentally, I saw all of the children with Strauss
15 in his school two or three years, worked closely with him on
16 these, and I feel now that what he described was mostly the
17 auditory involvement children in terms of newer pathology. By
18 the way, our neuropathologist would say it is the temporal
19 lobe case. Because they are the ones where you get this great
20 distractability and debilitation of behavior, Bill.

21 So along with this auditory you get this breakdown
22 in behavior in early life -- that is, early school life and
23 before.

24 Now, you can't put those in big classes. Here's a

25 population you have to handle down to six in a group, and so on.

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1 We have experimented, by the way, with three, four,
2 five, six, and so on, different degrees and ages, and they are
3 by far the most difficult to group.
4 The moment you get away from this population and talk
5 about those with dyslexia, you can group them in large classes.
6 They are easy to manage -- typically now. There are exceptions
7 always.
8 A certain segment of dyslectics are not that easy to
9 handle. But typically dyslectics as a group can be classified
10 into classes of ten, 12, 14, not more preferably, but you can
11 do good-sized classes with them if you have the proper instruc-
12 tional program and trained personnel.
13 We also make this assumption: That many of these
14 youngsters particularly with reading and spelling disorders
15 can be handled on an itinerant basis. Not special classes.
16 I would suggest that possibly eventually the big
17 percentage of your learning disability children should be
18 handled through regular classrooms with help through regular
19 teachers. This is my opinion on this and the way it tends to
20 work out very well time after time in these children.
21 You classify them in a certain way and you find
22 this group has different needs in terms of classification
23 than this group, and so on.
24 Does that answer it at all? Do you see what I mean?
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25 DR. HELLER: Yes. Well, as we have gone around the

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1 country this summer in regions and all, we have run into quite
2 a few programs that have been on the itinerant basis. They
3 have selected a teacher from an elementary classroom and sent
4 her back for some training, and then she has become an itinerant
5 specialist in learning disabilities.

6 DR. MYKLEBUST: Right.

7 DR. HELLER: I was just wondering how common this is.

8 DR. MYKLEBUST: It's going to be that way I think for
9 a long time. For one reason it serves more children, and the
10 personnel is extremely limited.

11 DR. RIDGWAY: Another pattern is the center where
12 youngsters are taken perhaps from the building in which they
13 are located, sent to another building in the district for
14 evaluation and some diagnostic teaching, until you find out
15 exactly how to treat the youngster, and so some of the people
16 who are being trained in this field teach classes where the
17 youngsters are itinerant in a way.

18 They come in and are there perhaps for four weeks,
19 perhaps six months. As soon as you get them moving, then you
20 try to get them back into regular classrooms.

21 DR. SELZNICK: I think in the long run though they
22 are going to have to look at services for children with learn-
23 ing disabilities on a continuum, because they are not a single
24 entity. And the kind of service and the frequency of service
25 will vary with different groups of youngsters. And so the

1 itinerant service is going to be adequate for part of this
2 population, but others are going to require-- And some will
3 benefit by going to a center, but there are others who will
4 find it necessary to spend the major portion of their schoolday
5 in a special environment and gradually be reintroduced into
6 the other stream. In other words, a continuum of services for
7 this segment.

8 MISS TAYLOR: Having sort of a resource room idea for
9 varying lengths of time according to the child.

10 DR. MYKLEBUST: This is used too.

11 Yes, Bill?

12 DR. WOLFE: We have been doing some predicting in the
13 last couple of days. How in the world are we going to handle
14 the MBI classes?

15 DR. MYKLEBUST: Minimally brain-injured?

16 DR. WOLFE: I don't know whether I mentioned this to
17 the group or not. In our State we have such classification,
18 and it's under the physically handicapped. And it is posing
19 major problems for us.

20 DR. MYKLEBUST: Like what, Bill?

21 DR. WOLFE: The certification bit. All that is re-
22 quired now is the same courses for the teacher of the physical-
23 ly handicapped, cerebral palsy and the whole bit.

24 DR. MYKLEBUST: I see.

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25 DR. WOLFE: I personally feel and members of our staff

1 feel that these are two very different areas. They are more
2 in the areas of learning disabilities as I understand it.
3 Also, our people do not understand what the word
4 "minimal" means. They think the brain is a little bit injured.
5 It's not that at all. It's symptomatology --
6 DR. MYKLEBUST: That's right.
7 DR. WOLFE: -- that is involved. What is happening
8 nationally? Is this something that is in every State, this
9 MBI program, or what?
10 DR. BLAIR: It varies with States tremendously.
11 DR. WOLFE: How do we cope with this?
12 DR. BLAIR: Wisconsin is using "special learning
13 disability." "Hyperkinetic" in Missouri.
14 Possibly one of the fruits of our endeavors here
15 hopefully -- although I don't know you can change these things
16 once they are on the books -- would be at least to begin to
17 reconcile some of these differences. I don't know now if it
18 is too late in some cases.
19 DR. WOLFE: It would seem to me the MBI should be
20 broken down, and those with brain damage which would cause
21 them to be cerebral palsied and obviously physically involved
22 should go that way. The others should be put in the learning
23 disability group and forget the MBI label.
24 DR. MYKLEBUST: Yes. I couldn't agree more.

25 DR. MYKLEBUST: This is the direction that your effort

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1 would be most worthwhile. I really must agree entirely.

2 I don't want to take time from the question of dis-
3 cussion to review, but just to mention the term "minimal" has
4 been discussed by the hours, has been thrown out. "Brain-
5 injured" has been discussed by the hours, and it is not really
6 apropos for most of them.

7 DR. WOLFE: No.

8 DR. MYKLEBUST: Well, I couldn't agree more. I think
9 if you go in the direction I thought you were suggesting yes-
10 terday in Texas that you were going towards learning dis-
11 abilities, it would seem to me it would greatly solve this.
12 I thought you were going to say with this designation you can't
13 put him in a class unless a neurologist finds him. See? This
14 is happening all over. You're getting into terminology which
15 is not educational. So the educator's hands are bound until
16 somebody says, "Well, look, you can have him."

17 DR. WOLFE: Right.

18 DR. MYKLEBUST: See?

19 DR. WOLFE: Right.

20 DR. MYKLEBUST: Now, this we are trying to help with
21 certainly in a great many different ways, because most
22 neurologists don't want this today. Please look at the last
23 issue of NEUROLOGY in which there is a whole page there,
24 combination of Council of Pediatrics and Neurology.

25 Now, the point is that most of these people don't

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1 want to be in the position of saying, "Look, you have got to
2 put him in this class." They don't know anything about this
3 educationally.

4 DR. WOLFE: That's right.

5 DR. MYKLEBUST: But we are putting the terminology in
6 such a manner that they are forced by regulation, if not law,
7 that they have to do it.

8 DR. WOLFE: That's right.

9 DR. MYKLEBUST: So I think it is unfortunate that
10 terminology has gone so far and will cause difficulties for some
11 time until we have some kind of retroactive effect.

12 DR. WOLFE: Finally, Mike, I would like to clarify
13 your interpretation of what I said the other night at the
14 dinner. And you interpreted what I said I think to mean that
15 I did not recognize the existence of a language disorder. This
16 is not correct.

17 I said I didn't fully understand what was meant by
18 this.

19 I feel -- I'm putting myself back in Texas -- I feel
20 that if we had gone the language disorder route in our legis-
21 lation this would have been a very narrow concept. We want
22 to include the language-disordered child but under specific
23 learning disabilities.

24 DR. MYKLEBUST: No, I knew you meant that. It was
25 Frank who was taking issue with it.

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1 DR. WOLFE: Excuse me.
2 DR. MYKLEBUST: I knew it, and when I was in Texas
3 I specifically tried to recommend to Dr. Barron and his com-
4 mittee that they not call it "language disorders," Bill.
5 DR. WOLFE: Everybody has recommended that to Dr.
6 Barron.
7 DR. MYKLEBUST: Of course, it didn't work. They went
8 that route anyway.
9 DR. WOLFE: Yes.
10 DR. MYKLEBUST: That's what it was turned down on.
11 DR. WOLFE: Right.
12 DR. MYKLEBUST: I think there if you got learning
13 disabilities it would have resolved some of this, don't you
14 think?
15 DR. WOLFE: Indeed so.
16 DR. DENO: I think we could get some help from the
17 U.S. Office of Education leadership. I was in there once on
18 a State Directors' meeting having to do with Title VI, and we
19 were talking about the different classifications in Title VI
20 and the means of their identification.
21 Some of us were working pretty hard to try to be
22 sure that learning disabilities did not require neurological
23 certification for the child to be eligible for service.
24 DR. MYKLEBUST: That's right.

25 DR. DENO: But it seemed the U.S. Office of Education

was a little reluctant to let go of the safety guard at that point.

DR. KASS: Yes, we had some of the history of this yesterday when Dr. Kirk went through his testimony and the misinterpretation of it in the Senate Report. And this is what the Office of Education used for the Title VI discussion.

DR. BLAIR: I will have to ask Corrine whether she feels that our definition of learning disabilities is less a can of worms than it was yesterday.

DR. KASS: Well, I never thought it was that to begin with.

DR. BLAIR: I know you didn't.

DR. KASS: I think you have several fine definitions and several fine programs. I am very happy, however, with this definition, and I am happy to have the backing of a group of professional people, as I am sure you are too.

DR. MYKLEBUST: Yes. I would like to try to explain a little bit more that-- I don't know why I didn't use this term before. You reminded me. But our conference is made possible under the rubric in the U.S. Office Bulletin "institute for advanced study." So we have been members of an "institute for advanced study." That is the way this is done. And, believe me, for me it has been an institute of advanced study. I mean you have helped me a great deal.

DR. DENO: This is why we have such a hard time

1 defining up there. That's such elementary stuff we think
2 anybody ought to know it. We're too advanced to try to define
3 that. (Laughter)
4 DR. SELZNICK: Are you ready for some comments?
5 DR. MYKLEBUST: Oh, yes. Ready right now. Go ahead.
6 DR. SELZNICK: I was going to explain what I meant by
7 that emotionally charged-- Where I am concerned, the word
8 "innovation" is emotionally charged like "Rafferty" in Cali-
9 fornia and some other terms, because I think it has come to
10 mean many things to many people.
11 But, anyway, the comment I really want to make is
12 I don't know who brought this particular group together,
13 whether it was Mike or Corrine or who, but I don't know that
14 I have ever been in a group where a group of people from dif-
15 ferent orientations, many of whom didn't know one another prior
16 to coming together, were able to communicate and to come to
17 basic agreements and to work as effectively with one another
18 in my long years in special education.
19 I think it's a compliment to the people that brought
20 them together and also to the other persons who are here that
21 they were able to relate so readily and easily to one another.
22 DR. MYKLEBUST: Thank you very much for your comment,
23 Harry. I appreciate it very much.
24 DR. WOLFE: We could have come together as this same
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25 group, and without the kind of chairman we had we could have

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1 sat here and looked at each other and gotten nothing done --
2 seriously -- because you are a driver, man. I can tell you.
3 (Laughter)
4 Two more days of this, and I could resent you.
5 (Laughter)
6 You go, go, go. I mean it's good, but two days and
7 a half would be enough.
8 DR. MYKLEBUST: You're wonderful.
9 DR. BLAIR: I wish some of our faculty committees
10 would do as well.
11 DR. WOLFE: Indeed.
12 DR. MYKLEBUST: Well, thank you very much, all of you,
13 for coming. It has been a great pleasure to work with you,
14 to learn to know you.
15 I do want to express appreciation to every one of you
16 and then to say that without Corrine's help all the way we
17 couldn't possibly have done this advanced study institute. She
18 has been most helpful and pushing with us all the time in order
19 to hold it and to accomplish it this summer.
20 I don't think she will mind if I explain a little
21 bit that funds were very limited for this purpose. We agreed
22 that we needed Mr. McLaughlin, that to keep this going we
23 needed it transcribed. Now, you all know that you will receive
24 a copy of this transcript just as soon as it is available.

25 There is going to be a lot of verbiage. But there is excellent,

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1 beautiful discussion in this. I hope you will look at it very
2 carefully.
3 I'm going to ask Corrine to help me to explore further
4 any editing process, and so on, that might make it better.
5 But you will all have to agree to whatever is done.
6 Now, the cost of having Mr. McLaughlin here -- he is
7 an expensive guy, you see -- is such that we didn't have much
8 money left for you people, as you well know. I'm explaining
9 why we couldn't go the usual route for your honorarium. It just
10 wasn't possible -- not that and have transcripts. So we took
11 the route of transcript, which I hope in the long run is
12 going to be of great benefit, if not monetary, to you.
13 Now, with that, again I say I greatly appreciate the
14 time and effort that you have given to this study, and I expect
15 that we will be in touch with you pretty soon, as I think
16 Mr. McLaughlin has assured us that the transcript will be
17 available to us quite soon -- not tomorrow, but fairly soon.
18 We have only one copy for each of you, by the way,
19 in the estimate of costs involved. We have only one copy for
20 each of you. That will be your copy to keep, to use for all
21 further reference in terms of what will be done with the
22 material produced here.
23 Now, I should think then that early this fall we'll
24 be ready to explore with you by letter how you are coming
25 with it, what you think about it, and I think by then perhaps

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1 I could have a chance to go over this with Corrine further and
2 we would know something more about what we could suggest.
3 Remember we said before that we will need help in
4 lists of organizations or at least the heads of organizations
5 that should be included, because we're going to have to work
6 out a way to get more copies than we have ordered now.
7 But it seems to me that it might mean copies after
8 editing, to reduce expense, and so on. The ones we have now
9 will just be once around, one for each. That's all we have.
10 Again, thank you very much. I look forward to seeing
11 you all again soon.
12 (Whereupon, at 2:45 p.m., the Conference was
13 adjourned.)
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