CHAPTER I
ORTHOPEDAGOGICS AS A SCIENTIFIC FIELD OF PEDAGOGICS

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1. Background and rise of othropedagogics

As is known, since World War II there has been an increasing interest in orthopedagogics as a branch of pedagogics—or, as I prefer to call it, a part-perspective of the science of pedagogics. Its history indicates that, from the beginning of the 18th century, orthopedagogic work has been carried out in a variety of institutions, where it was demonstrated that children with deficiencies and/or deviations deserve care, training, and loving treatment for the benefit of these children, as well as for society. However, it was only later in the century that classes and schools for certain destitute children were called for, i.e., for deaf, blind, and mentally deficient children. Here one thinks, respectively, of the first institution for the deaf of Abbe de l'Epee, in Paris in 1770, the first institution for the blind of Valentin Hauy, in Paris in 1784, and the first institutions and schools for the mentally deficient of Guggenbuhl, in Switzerland, and of Seguin, in Paris in about 1840. (1)

Until the end of the 19th century, a pre-scientific period(2) prevailed where helping children with physical deficiencies was of a practical nature. If a child had a profound "character defect", it was not thought about pedagogically, but was moralized about. It is understandable that, with the rise of psychology, especially psychoanalysis and psychiatry with it, at the end of the 19th and beginning of the 20th century, a more scientific approach to children's deviations and deficiencies arose. Here, one thinks of Ludwig Strumpell's **Paedagogische Pathologie** (**Pedagogic Pathology**), which appeared in 1890, and in which there was an effort to view deviant behavior from a scientific perspective. During this same period, there was the rise of psychoanalysis, and the analysis and treatment of children's deviancies became a matter for psychoanalysis and, thus, for psychiatry. Here one thinks of Hans, the five-year-old boy who, in 1907 came to the attention of Freud for treatment of anxiety. (3)

It is well known that during this century, child analysis and child psychotherapy became part of the psychoanalytic school of thought which, in due course, also developed into various branches, some of which had drifted away from psychoanalysis. For example, the nondirective therapy of C. Rogers, et al. is viewed as a psychological approach. This, and other ways of psychologically approaching child psychotherapy arose, especially after the 1930's.

It is very important to indicate that the psychoanalytic, as well as the psychological approaches hold to a naturalistic anthropology, with the consequence that, amidst these naturalistic approaches, during the last two decades (1950's and 1960's), an anthropological-pedagogical-existential therapy has developed, or also an anthropologically accountable pedotherapy. This modern, anthropologically accountable pedotherapy--or also personological pedotherapy--which is the outcome of a 20th century philosophical anthropology, was deemed to be urgently necessary because the psychoanalytic-psychiatric-psychological approaches shove the pedagogic entirely into the background. [(4)]

However, the scientific approach during this century was not only directed to the child with affective-striving disturbances but to the restrained child in his totality, i.e., with respect to teaching and educating the blind, the deaf, the orthopedic handicapped, the epileptic child; briefly, with respect to the physically handicapped and mentally deficient child. Especially after the 1930's, attention was given to children with learning difficulties or, as this is called today in the Netherlands, children with learning and educative difficulties. In the Anglo-American countries this is known as "remedial education". Although the work of Heinrich Hanselmann in Zurich, **Einfuhrung in die Heilpaedagogiek** (**Introduction to Therapeutic [Healing] Pedagogics**), which appeared in 1930, is still within the psychiatric-psychological school of thought, it is the first work to deal with the question of the child with deviations and/or deficiencies in such a comprehensive way.

Actual pedagogic intervention with children really emerged after the second world war, thanks to the rise of a modern philosophical-anthropologically founded pedagogics on the European continent, especially in Germany, Switzerland, Holland, and Belgium, and which has been practiced and expanded in South Africa by the Faculty of Education, University of Pretoria, since the beginning of the 1950's. In this regard, it is well to mention that the

development of teaching the restrained child—physically, as well as psychically-spiritually restrained—has approximately followed the same pattern as in Europe, i.e., that the blind and deaf enjoyed attention in the early years, after which the mentally retarded (from the 1930's on) were focused on, while the cerebrally handicapped, and children with learning difficulties came into the foreground in the 1950's.

The teaching of and educative intervention with the physically and/or psychically-spiritually restrained child, as briefly sketched here, over time hiss acquired various names. In German speaking countries, the name "Healing pedagogics" or also "Special pedagogics" were used, in English speaking countries, there is mention of "special education", in South Africa the name "special education" or "exceptional education" were used. With the rise of a more pedagogical approach, after the Second World War, the name orthopedagogics, as a more comprehensive concept, came strongly into the foreground, especially in the Netherlands. Here there is reference to the **Tijdschrift voor Orthopedagogiek** (**Journal for Orthopedagogics**), which began in the Netherlands in 1961, and in which "orthopedagogics" is consistently used. This does not mean that we know precisely what is meant by orthopedagogics. On the contrary, the many-sided nature of the teaching and educative intervention with the restrained child hinders a scientific description of the concept as far as the content is concerned, the field which it covers, and its place within pedagogics as a science. Thus, we are dealing with a young science--a part-discipline of the pedagogical about which a great deal of thought is still needed. Here an attempt is made to briefly clarify the concept "orthopedagogic" and to account for it within the framework of the pedagogical.

2. The pedagogical foundation of orthopedagogics

According to Vliegenthart, orthopedagogics can be described as the theory--or also science--of the "educative activity" provided on behalf of the child who, because of his unique psychic and organic structure, is seriously restrained in his current educating. What is more precisely meant by orthopedagogics perhaps will become clearer. What must be emphasized is that it is a **science** of a **pedagogical or educative activity.** Thus, it entails reflecting on a phenomenon of an unusual circumstance. This phenomenon is that of an adult facing a child, and which constitutes a **pedagogical**

situation. The **unusual circumstance** is a child who is restrained, with the consequence that educating and teaching him differ from that of a normal child.

To indicate the pedagogical foundation of orthopedagogics it also is necessary to take the pedagogic situation as the point of departure, and to illuminate aspects within it which are of fundamental significance for any child, also a restrained child, in his becoming adult. Although these aspects have been phenomenologically analyzed and illuminated by various writers, e.g., in the Netherlands, Germany, and here in South Africa, still it is necessary to briefly name them and indicate their connection with orthopedagogics for the sake of an ordered course of thinking. According to the phenomenological-anthropological view, being a person, as a physical-psychic-spiritual being, thus, as **Dasein** and, thus, is an existential being who continually is meaningfully involved in his world, and who is always in an existential situation. Thus, one can view the child, in his becoming adult, nowhere else than within his situatedness, i.e., within the existential situation of an adult facing a child. But, as soon as one views the becoming child from this situation, then one arrives at the anthropological truth that, as Langeveld says, a person is the only being who educates, is educated, and is dependent on education. The situation within which an adult and child communicate, necessarily constitutes itself as a pedagogical one.

If the pedagogic situation now is penetrated and analyzed phenomenologically, the following aspects or mpmrnts, as functioning essentials, can be illuminated. **First,** it is noticed that a little child is **helpless** and, thus, **seeks help and support**. This appeals to the adult to give help and support. How much more will a restrained child have a need for help and support, and how much more will this direct a stronger appeal to the adult to provide this help and support. It is understandable that, under such circumstances, pedagogic intervention will be more intense--possibly different. Help and support by the adult do not imply that the child passively accepts them. He is always **Dasein** and is directed to his world as wanting-to-be-someone himself and, thus, wanting help and support. When a child is deviant or deficient, the need for help and support is greater.

A **second** inseparable aspect connected with the pedagogic situation--indeed, what makes it a pedagogic situation--is

sympathetic, authoritative guidance, and the discipline related to it. This has to do with an adult being invested with authority which he is obligated to exercise in facing a child who, in his helplessness, shows respect for authority, and accepts it in his search for direction and guidance. The emphasis is on **sympathetic** because the exercise of unsympathetic, unloving, dictatorial authority will allow all pedagogic intervention to fail. This holds especially for a restrained child who is very sensitive to his deficiencies and/or deviations, who is usually more directed to the pathic than the gnostic, and who often is strongly vital-bound and, thus, his affective life becomes flooded, especially in a formal [school] pedagogic-didactic situation. This does not have to do with obedience as mere docility, but with the recognition of the demands of propriety and respect of and deference to the person who is the conveyer of this knowledge. When the restraint is a serious mental defect, it is understandable that the demands of propriety will be difficult to understand on a gnostic level, and sympathetic, authoritative guidance becomes a more difficult task.

A **third** meaningful aspect in the pedagogical situation is the relationship of **responsibility** of the adult, as a person, for the child as a not-yet-responsible person. Responsibility is a spiritual or existential potentiality in the child which must be gradually awakened and actualized by pedagogic intervention (by giving help and support in recognizing and respecting demands of propriety by means of sympathetic, authoritative guidance). The child is continually confronted with all kinds of values in life and is placed before all sorts of decisions. The help and support, and the exercise of authority must be such that they help the child, on his **own responsibility,** to find choices, make decisions, and carry out activities. Here an educator-teacher is faced with an extremely important task when, in a pedagogic situation, he finds himself faced with a child with physical and/or psychic-spiritual deficiencies and deviations, and, in this connection, he must remember that each handicapped child, according to his deficiencies and/or deviations, has a unique world relationship which the educating and teaching he has received have hampered in certain ways; and, consequently, **other** action must be taken with such a child.

A **fourth** important educative aspect is that the situation is directed to the child **becoming morally independent,** or an adult. It is understandable that the aim is to bring each child, also the

physically and/or psychically-spiritually restrained, to adulthood but, indeed, moral adulthood, which implies an adult who obeys authority and accepts responsibility. However, one must be cautious in stating adulthood as an aim, because one can make the image of adulthood so idealistic that it is unattainable even for a normal child. As far as the restrained child is concerned, his deficiencies and/or deviations can be such that he can never reach the ideal of moral independence. However, this need not be a criticism [5] of striving for moral independence, as a form of being adult because, **as far as a restrained child is concerned, he is striving for the eventual form of adulthood, which is within his reach, given his deficiencies.** Paul Moor stresses this point by first indicating that "Above all, healing or therapeutic pedagogics has no other general aim than the pedagogic. Hence, healing pedagogics is pedagogics, and nothing else."[6] "Healing pedagogics" or orthopedagogics is nothing more than **pedagogics** and, thus, strives for the same aim but, according to Moor, the particulars of orthopedagogics are in the fact that its activities are carried out under more aggravated, and difficult circumstances. In each individual case, therefore, it must be recognized that there are insurmountable limits, and it is within these limits that the educative tasks must occur or be carried out. Consequently, the educative aim to which the orthopedagogue must direct himself cannot be dogmatic and fixed because, often it appears that the preconditions for reaching such an aim are not present for a child, so that the prospect of actualizing educating itself is viewed as hopeless. For this reason, Moor stateses the aim of educating in orthopedagogics as follows, "We want to help the child, such that he finds fulfillment in his future life which is possible for him."[7] By "fulfillment" is understood that, in addition to a person's destiny, also included is a task and a promise. The limitation, "wgich is possible for him", refers to the readiness to consider what cannot be changed about the child.

In summary, it is noted that implementing the mentioned fundamental aspects or moments in the pedagogic situation is aimed at forming the child's conscience--whether a normal or a restrained child. Thus, for pedagogics, as well as orthopedagogics the basic aim is forming conscience. These four educative aspects are sufficient to show that **orthopedagogics is primarily pedagogics** and, thus, functions in a pedagogic situation as a **part-perspective within the framework of the science of pedagogics.**

This standpoint can be developed further by showing that it also holds true when one fathoms the child in his **becoming** within a pedagogic situation, and illuminates certain **pedagogical moments of becoming,** ,r what Langeveld[8] calls developmental moments or principles. The name **pedagogical moments of becoming** is chosen here because human becoming, or also a child's personal becoming, can only be actualized (responsibly) within a pedagogic situation. Langeveld and Buytendijk show how, viewed anthropologically, humanizing precedes a child's becoming, and that this is followed and perfected by educating and, thus, is included in educating. A child comes into the world as a biological phenomenon with humanly disposed potentialities. Langeveld calls this phenomenon the **biological moment**. If one observes a child in his biological appearance, then his **helplessness** is noticed immediately, as the second pedagogical moment of becoming. It is this helplessness which sets humanizing and educating in motion because it directs such a strong appeal for help, to the parent that **loving care** appears in the pedagogic situation, which puts humanizing-education into action. As a result, the child's helplessness and, thus, feeling insecure is transformed into **feeling safe and secure,** which arises as the third pedagogic moment of becoming. The feeling of security results in the further actualization of the child as "Dasein". A child who remains helpless and insecure, e.g., by faulty loving care, or serious personal deficiencies, even if there is loving care, also remains stuck in the biological-vital, and does not become humanized, at least not readily. When security arises, so also does the fourth pedagogical moment of becoming, i.e., **exploration**, i.e., the child **ventures** by going out to his little world to explore it unaided. Inseparably bound to exploration is a striving by each child to **want-to-be-someone-himself,** which is an additional pedagogical moment of becoming.

It is understandable that physical and psychic-spiritual deficiencies will have an extremely important influence on the pedagogical moments of becoming. A physical deviation already noticed at the beginning of a child's life, in his biological appearance necessarily influences the nature of the pedagogic intervention (loving care), such that it can lead to the unpedagogic action of over-protection. Supposing, however, that the pedagogic action always remains on an acceptable level throughout the life of a child with deficiencies and/or deviations, it will be **different** than for a normal child because this child, with his strong bodily **lived experienc**e will

constitute a **different experiential world**** than a physically normal child. In this way, the pedagogical aspects of becoming will be functionally impeded. Whatever deficiencies or deviations a child might show, the functioning of the pedagogical moments of becoming will not only be seriously disturbed in the early years of childhood, but right across the school years, and even beyond. Intensive research in our orthopedagogic institute with mentally deficient, deaf, poor-sighted, epileptic, and brain-damaged children, and children with learning and educative difficulties has shown that the parent, as well as the educator-teacher is faced with a pedagogic task with these children because the way they constitute and relate to the world is continually **different** from the normal child. Here, reference is to the findings of Sonnekus[9], Pretorius[10], Kapp[11], Mrs. Erasmus[12], Kotze[13], Van der Hyde[14], Nel[15] et al. For example, in connection with the poor-sighted child, Sonnekus says, "As a rule, it is found that these children are unconsciously struggling against their total bodily being restrained, while only an **experience** of the eyes decreasingly enters the foreground ... These children are continually in **affective distress**, are unrestrained, affectively poor, and blocked, as well as infantile in their outlook."[16] Again, Van der Hyde says, "The child with poor vision is someone who, as a consequence of his physical defect, is limited in his exploration and reconnoitering of the world, and he has a great deal of insecurity, tension, and feelings of being unwelcome. With children of poor vision, there is a strong intention to achieve and, in this manner, to compensate for their physical defect."[17] The otherness of the deaf child, in the light of his world-relationships, and the correlated pedagogic tasks, is reflected in the research of Nel, Kapp, and Erasmus. All these studies involved establishing a person image of deaf children in a pedo-clinical context. A child intensely **experiences** his hearing and language defects, an **experiencing** which is strongly affect-laden, and which handicaps him in feeling safe in exploring his world. Where a blind and weak-sighted child is mainly dependent on a haptic and acoustic world for his spatial orientation, a deaf child is dependent on the visual before him, on gestures, and on the eventual acquisition of language for continually constituting his world.

** I translate lived-experienced world (beleweniswereld) as experiential world --G.Y.

One finds this impediment in constituting a world even more pronounced in children with multiple defects, such as, e.g., brain damage. Kotze's finding, in this respect, is meaningful: "The brain damaged child lets himself be known as **other,** in his situational relatedness, in the sense that he establishes different relationships with reality. It has gradually become more obvious that this child struggles with his unique physicality, as a body-with-deficiencies, which he pathically **experiences** his body-ness, such that this floods him and makes it difficult for him to arrive at a gnostic attunement to reality." Regarding my own research, it is sufficient to indicate the tasks confronted by the parent and educator-teacher in the pedagogic situation within which he must provide help and support for the becoming child with deficiencies and/or deviations.

Thus far, it appears that the restrained child, just as the normal child, always finds himself in a pedagogic situation and, thus, is subject to the aspects of becoming included there, and which the educator's aim is to potentialize and actualize his spirituality (conscience forming). Dumont emphasizes this aspect in the following words: "The aim of educating the deviant, handicapped child, the child in 'educative distress' (Van der Zeyde), in principle, is the same in orthopedagogics as in educating an ordinary child; actually, it often becomes relativized by the imposed limitations, the child's diminished educability ... The difference between orthopedagogics and pedagogics is in the difference between educative means, where the orthopedagogues' educative attitude is clearly the most important factor. But this difference in educative means is not such that, within the orthopedagogic, other means are used than in an ordinary pedagogic situation". ([18)]

According to Dumont, "This difference ... lies in the fact that the **same** means are used **differently**, more frequently, more or less emphatically, for a longer or shorter duration, more carefully or deliberately." Orthopedagogics is pedagogics, it rests on the same foundation, but is an expansion into a unique part-discipline (of pedagogics) because it is concerned with a child who **differs** from an ordinary child. The restrained child's being-different has already been broached many times, but the question is what the nature of this difference is, and what is its pedagogical significance. Space does not allow us to go into the particulars of the question of the child and his world relationships. However, briefly, this concerns the child's "Dasein", his being-there, his existential being-in-the-world, which also means "Mitsein" [being-with] (Heidegger). Thus,

as Dasein, he is continually directed to his world, attributes meaning to the things and events in it and, in this way, constitutes his own experiential world. In this regard, Vliegenthart[19] indicates that a normal child who has normal sensory organs, the normal range of motor skills, the means of ordering his intellect, and an emotional accountability is able to **choose** how he is going to constitute or design his world. A child's experience of the freedom **to choose** is limited by all forms of restraint, a limitation which, in the first place, is not experienced as a lessening of the possibility to constitute a unique world. It really is experienced as being unable to live in a world which "belongs to others". A child with disturbed motor skills is prevented from participating in the many games of his peers; this also is the case with a congenitally deaf or blind child. In addition to this, there is the experience that the other children obviously have information about things which they don't have. Then, Vliegenthart says, "The daily experiential world of these children cannot be our exclusively shared world, but differs mainly by a personal accent, which makes or can make it different. **That his world is different is an unavoidable facticity** (Nel's emphasis). A child with intellectual deficiencies experiences very early being outside our world, and this does not become less profound and burdensome later."[20] Vliegenthart continues by indicating that, in interacting with this life, because of a different-bodiliness-world, the restrained child develops himself into a different person. As a unique being, a child makes or constitutes his world differently, and the resulting opposition of the world, in turn, influences him as a person, and he experiences failure, being rejected by peers, being seen as different (as a cripple, deaf, etc.); the demands of being so different make the restrained child feel that he must not be "really like them", and the uncertainty of the educators whose intuitive naturalness in behaving with such a child is lost, all play a role. It is precisely in this regard that orthopedagogics still falls short, i.e., the study of the unique or different world of a restrained child is still at its beginning. As far as the intellectually less gifted child is concerned, we can say that his thinking moves on a concrete level, that it is unordered, that he acts impulsively, etc.; viewed positively, we do not yet know what the **experiential world** of these children is like. More specifically, as far as the mentally deficient child is concerned, Langeveld has said, "We need an anthropology of the mentally deficient (...) for us to grasp the mentally deficient person, as a meaningful form of human existence."[21] Vliegenthart

notes that the educator must know this unique existence to be able to help him live his being-different with human dignity.

Consequently, orthopedagogics is inseparably bound to the pedagogical as a science; indeed, it is rooted in the pedagogical, and arises from a phenomenological penetration of the child restrained in becoming in an educative situation and, thus, should be viewed as a part-discipline of pedagogics.

3. The orthopedagogic as a complex scientific structure within pedagogics

Where in the previous section, an attempt is made to demonstrate that orthopedagogics is pedagogics and, thus, is rooted in it, in this section the emphasis is on the fact that orthopedagogics is **a complex scientific structure**. We are dealing here with a **young science.** It is important to indicate its complexity and many-sided nature in its continual development as a part-science of the pedagogical. In this complexity, and many-sidedness it is seen that, first, it is concerned with a child in his **pedagogic situation.** For this, it is necessary that the orthopedagogue have knowledge of theoretical pedagogics, as the core discipline, and of all of the part-sciences, especially psychological, didactic, social, physical, and vocational orientation pedagogics. Second, it is concerned with the **restrained** child in his pedagogic situation. Thus, in addition to the above part-sciences of the pedagogical, a related subdivision of psychological pedagogics is of fundamental importance here, i.e., the doctrine or theory of the child with deficiencies and/or deviations in his physical-psychic-spiritual structure, as they manifest themselves in his world relationships, or also the psychology of a child's being-different in his becoming toward adulthood, i.e., a pedagogically situated becoming.

As noted above, physical handicaps play an extremely important role in constituting a different world. However, it is important to indicate that the science of medicine, as a **supporting** or auxiliary science, has a significant role to play in physical education (physical pedagogics) as a part-science of pedagogics. In other words, physical pedagogics, as part-science of pedagogics, is dependent on numerous related sciences, such as physiology, medicine, with all its branches, biochemistry, etc. as **supporting sciences.** The different world constitution of the brain damaged child, or of the epileptic child are linked to the fact of his brain damage and its nature,

which can only be investigated and confirmed neurologically; indeed, a physician is necessary regarding a deaf, blind, hard of hearing child, one with poor vision, the chronically ill child, etc. The importance of the significant role of medical science in this respect certainly cannot be appreciated too much, but it is just as important to indicate that **here the science of orthopedagogics always must be at the center,** because the point of departure remains the child in his pedagogic situation. Thus, a physician can never be a pedagogue, and is not a child's teacher-educator; he remains a colleague in the pedagogic situation, who must provide the pedagogue and/or teacher-educator with the extremely important medical knowledge and means of treatment which are accountable regarding the pedagogical and pedagogic-didactic forming of the child in his differently constituted world with all its problems. This knowledge and treatment of a physically retarded child is immediately implemented by the orthopedagogue, orthodidactician on the child's behalf. This knowledge enables the orthopedagogue to know the state of the physically handicapped child, and what pedagogic and didactic means must be applied in the situation to help him in his becoming adult.

Similarly, orthopedagogics (and pedagogics) can make use of other supporting sciences. Here one thinks of other human sciences, such as psychology, ethics, and sociology, which sre not considered. However, it is emphasized that these sciences will be of less--if of any-- value if they emanate from a naturalistic view of persons.

With all the knowledge of the restrained child--theoretical-pedagogical, psychological-pedagogical, social-pedagogical, medical, etc.--the orthopedagogue must treat or help the child. This helping action which, at its core is pedagogic action, on closer analysis, appears to be a **particular and specialized helping**. With this, we return to the definition of orthopedagogics in section 2 above, i.e., that it is a science of educative action on behalf of a child who, because of his psychic-spiritual, and organic structure, is seriously restrained in ordinary educating. Note, it is because of this restraint in ordinary educating which particular and specialized educative activity is necessary, which can lead to **re-educating** the child. It is an act of re-educating because, with the usual methods of educating and teaching, the restrained child will not attain the highest form of adulthood of which he is capable, given his restraints. This particularized and specialized helping the restrained child, as orthopedagogic help, embraces two aspects which can be

distinguished but not separated, i.e., the **orthopedagogic** or existential, spiritual formative aspect, where the emphasis falls on activating and potentializing the spiritual dimension of the restrained child (such as awakening responsibility, the deepest religious feelings, a sense for values, etc., thus forming his conscience); and the **orthodidactic aspect**, where the educator-teacher and the restrained child find themselves in a didactic situation, e.g., a formal teaching situation which has to do with instilling the learning content in the involved child, and his mastering it by applying particularized and specialized teaching methods, which try to bridge the learning difficulties caused by the restraint. Consequently, orthopedagogics embraces the **orthopedagogic,** as well as the **orthodidactic.**

The question which arises here is whether the specialized educative approach, thus, the orthopedagogic aspect, must be distinguished from the usual pedagogic or educative aspect which one finds in a family or an ordinary school. If Grewel's explanation regarding this is correctly understood, then he views the specialized educative or orthopedagogic aspect, as sketched here, as merely **pedagogic** help, which is executed in the same way by the educator-teacher in an ordinary school. For example, with reference to "educating" a deaf child, he says there is the danger that the pedagogue will engage in therapy, and then says, "However, a deaf child doesn't receive therapy from the teacher, **but is helped pedagogically** (Nel's emphasis) ... This holds for the poor learner, the slow child, the deficient, and difficult child. The educator's task, and that of these children and youths is education."[(22)] According to Grewel, helping the restrained child, as pedagogic help, cannot be differentiated from pedagogic help for a normal child--he contends that, in neither case is it therapy.

The standpoint endorsed here is that the restrained child, as "Dasein", is a being-different because of his restraints and, thus, he constitutes for himself a different experiential world. Consequently, the teacher-educator must encounter him in this different world, and approach him with particular and specialized actions in his attempt to re-educate him. These particular and specialized actions decidedly are, **in particular respects, different types of actions than the usually pedagogic,** and which are orthopedagogic in the narrow sense of the word, and are pedotherapeutic in nature. In this sense, orthopedagogic actions aimed at the spiritual or existential dimension are synonymous with pedotherapy.

It is very difficult to determine the boundary between ordinary pedagogic help and orthopedagogic or pedotherapeutic help. In this regard, nevertheless, it is commonly accepted that the image of the different world of the restrained child is strongly affect-laden, and hinders the actualization of his "Dasein", and world orientation. The affect-laden nature of the world relationship of the restrained child is inseparably bound to the fact of the acceptance of the restraint, whether physical or psychic-spiritual. What **experiences** must a deaf, blind, brain damaged, crippled child have when he finds out that he cannot carry out activities that other children can? Hence, the experiential world of the child with debilities is one of feeling frustration, inferiority, awkwardness, isolation, of not being-able-to-keep-up, etc. However, it is not only the restraint which is responsible for the different affect-laden nature of this experiential world, but also contributing is the situation in which he finds himself, and especially the parent-child situation. In this connection, Vliegenthart[23] says, "It is a familiar experience that the relationship between parents and handicapped children has a higher risk of being restrained by various influences than is the case with the non-handicapped. This means additional difficulties in educating; indeed, difficulties not stemming primarily from the deficiency [as such]". In such cases, parents are confronted with extremely difficult tasks. An extremely important factor in this regard is that often parents are deeply shocked by the fact that their restrained child does not progress in the direction of the future image [about their child] that they represent to themselves. In this regard, the phenomenon of overprotection is mentioned, which makes educating difficult. The difference between pedagogic and orthopedagogic measures also is presented by Valk. He emphasizes the spiritual aim of orthopedagogics, and then says the following: "Where ordinary educative measures are adequate for attaining this aim, one speaks of the pedagogic. Where unusual measures are present, one speaks of the orthopedagogic."[24]

In the above, the orthodidactic aspect of the orthopedagogic also is indicated. Indeed, it is an inseparable part of orthopedagogics. There is a tendency to separate it from the orthopedagogics and reduce it to a technique such as one finds in the Anglo-American notion of "remedial teaching". In such a case, attention is focused on the shortcoming and not on the child as a person in his world relationships. This matter is dealt with by Prof. M. C. H. Sonnekus in Chapter IV and is not discussed further here. However, the

standpoint is **this**: whatever shortcoming a child might have includes shortcomings regarding his learning world, as an experiential world, which are going to be linked up with helping the child as a person in his differently constituted world, thus also with orthodidactic help, where there is mention of certain orthodidactic methods and aids.

Thus far it is accepted that we become acquainted with the restraints of each child, and then immediately proceed to providing orthopedagogic help (N.B. we do not speak of **treatment**--a term from the medical world with medical connotations). In fact, it is a complicated procedure to diagnose* the child's restraints. In previous years, this was merely a medical or medical-psychiatric diagnosis, while the practitioner, or teacher perceived the teaching aspect intuitively and, from experience. In the decades just past, but especially in the post-World War II years, a complex evaluative procedure was developed in which the pedagogic is not only done justice but is its central starting point. Such a thorough evaluative procedure is necessary because it lays the foundation for the nature and form of helping the restrained child. Without going into details--because they have been expressed in many of our writings [(25)]--it can be mentioned that there is a naturalistic—and, thus, a natural science oriented diagnosis, better known as psycho-diagnosis, which contrasts with a more pedagogically oriented evaluation. Contemporary psycho-diagnosis is based on a naturalistic-evolutionary construed anthropology of a person as a bio-psychic being, as a conscious being with psychic functions, which are measurable and, thus, quantifiable. It is based on the excessive use of tests and test results, which are mainly interpreted quantitatively. Pedagogic evaluation or pedo-evaluation and, thus, also orthopedo-evaluation is based on an accountable personological anthropology by which a person is viewed as a somatic-psychic-spiritual being, primarily as a spiritual or existential being and, thus, as a **person** in his world relationships. On this ground, a totally different approach to evaluating a person or also a restrained child arose--thus, an anthropologically accountable orthopedo-evaluation. Space does not allow going into the particulars of the approach (for more particulars there is

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* I translate orthopedagogic/orthodidactic diagnosis, diagnostication as evaluation but I leave psychiatric, psychological diagnosis alone to keep it in the idiom of the medical model--G.Y.

reference to the author's **Fundamental orientation in psychological pedagogics**, Chapter IV). Briefly, it is indicated that the point of departure of this approach is the phenomenological method, i.e., the phenomenological analysis of the child of concern in his situation. In this connection, the **association** and **encounter** with the child, the **conversation,** and **observation**, as fundamental pedagogic methods are of primary importance. The pedagogue, respectively orthopedagogue, makes use of **exploratory media**--known as "tests" in contemporary psycho-diagnosis--applied as aids which also are primarily interpreted phenomenologically, and on this basis, a qualitative analysis is made of the eventual actions of the child. As a rule, this involves an analysis of the child in a pedagogic situation and not so much a measuring of psychic functions and achievements. Such an orthopedagogic evaluation also includes an orthodidactic one. In other words, any child who must be evaluated for learning difficulties (thus, orthodidactically) mudt undergo an entire orthopedagogic evaluation, because this has to do with the child in his world relationships, and not with partial defects. The anthropologically accountable pedo-evaluation is considered to be so important that, even when normal children are brought to our Child Guidance Clinic for vocational orientation guidance, such a child undergoes this evaluation.

Finally, we arrive at a most important difference between current psycho-diagnosis and pedo-evaluation, or orthoped-evaluation. In agreement with the naturalistic view of a person, a psycho-diagnostic approach is one of compartmentalizing, and from this point on arises the notion of "teamwork" among the physician (and/or psychiatrist), the psychologist, the sociologist, or social worker, and the pedagogue. In this constellation, really the pedagogue plays a very small role. The data from each of the experts is eventually pooled, from which a "personality profile" is constructed by all of them, after which a "treatment" (N.B. not giving help) is selected. How an accountable unitary image--**a person image**--can be acquired from a medical investigation, psychological data based on measures, social data (the so-called "case history" data) is not clear. Indeed, only a peripheral "personality profile" can be compiled peripherally because it is not a person image which is viewed from the existentiality of being a person.

In a personological oriented pedo-evaluation, respectively, orthopedo-evaluation, there also is a **team** working, **all with**

fundamental pedagogical schooling and especially in psychopedagogics (respectively, psychological orthopedagogics), didactic pedagogics (respectively, orthodidactic pedagogics), and social pedagogics (respectively, social orthopedagogics). A necessary addition to the pedagogically schooled team is the physician.

As far as possible, however, the investigation of a child, except for a medical or psychiatric investigation (where necessary), should be undertaken by a psychopedagogue (respectively, orthopedagogue). **As far as possible**, it should be undertaken by one expert--preferably a psychopedagogue--because it is not always possible that one person is so broadly schooled and, for this reason, in the team there are those who, e.g., have been particularly trained in orthodidactics, play evaluation, in the use of language, as an evaluative medium, and in vocational orientation evaluation, whose help can be enlisted for certain children. However, for whatever problem or restraint a child is investigated, he must be subjected to a complete pedo- or orthopedo-evaluation. The role of the teamwork does not concern so much mutual help with the evaluation, but with the team or panel discussion, where the investigation of each child is presented by the various investigators or evaluators and is discussed by the entire panel. The following can result from this:

a) More comprehensive and deeper deductions regarding the compilation of the child's person image;
b) further research in connection with certain aspects of the structure of a person in his world relationships, e.g., factors in connection with family background, possible pedagogic neglect, further orthodidactic investigation, etc.;
c) referral to a medical specialist for possible neurological or for endocrinological investigation; or for audiological study.
d) choice of the nature and duration of the assistance, e.g., pedotherapy, orthodidactics, vocational orientation;
e) decision that a conversation be conducted with the parents--by who?

4. Conclusions

In this chapter, an attempt is made to provide an image of orthopedagogics as a part-discipline of pedagogics, as it has developed in the last two decades after the Second World War. The

importance of this development is, first, that the orthopedagogic is viewed from a modern philosophical-anthropological foundation and, second, that an accountable anthropological-pedagogical view has stemmed from this, a view in which the **pedagogical,** for the first time in history, is done justice. The following chapters attempt to show how complex othropedagogics is, as a scientific structure within the more comprehensive scientific structure of pedagogics.

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