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The Search for an Integrated Paradigm of Care Models for People with Handicaps, Disabilities and Behavioural Disorders at the Department of Orthopedagogy of Ghent University

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Abstract: This paper reviews underlying systems of worldwide thought, which underpin the organisation of care, support and (special) education for people with disabilities and behaviour disorders. As the world enters a postmodern age, there is no longer one central and dominant theory by which to guide action. The article reviews a range of theoretical positions, which have supported intervention for people with disabilities and behaviour disorders. It traces historical development of one institution, Ghent University, in the field of orthopedagogy in order to understand how systems of thought have developed and influenced practical action. The paper also provides a critique of existing models of care and (special) education, which sets an agenda for change.

Action in the field of disability has historically taken the form of *intervention* undertaken by professionals, in which concepts of simple dichotomies: normal/abnormal, sick/healthy, able/disabled, are no longer tenable. This paper argues for a new paradigm of understanding in order to better support professional "reflection in action" (Parker, 1997). Reflection in action in the field of disability is constrained by theory, or theories, which lead to a cycle of planning and intervention (Schön, 1987). It is also controlled by institutions, which provide professional development in terms of their institutional discourse (Foucault, 1970).

In the Netherlands and Flemish Belgium — the *Low Countries* — intervention in the field of disability has taken place within a discipline known as "orthopedagogy."

The word orthopedagogy derives from Greek: the prefix *orthos* meaning *right* or *correct* and the word *ped* or *pais* meaning *child*. *Agogy* originates from *agein* and means *action* or *doing*. "Pedagogy" is the "science of education," and the prefix *ortho* distinguishes it from *ordinary* education, in that it implies a *return to order* (normality).

Orthopedagogy is defined as a return to *correctness* through use of educational theories and more specifically as a science of action aimed at children and adults experiencing difficulties in educational situations.

The Dutch orthopedagogue Gieles (1992, p.304) describes this action as "seeing man as a being who can act — that is: who can give meaning, set aims, standards and rules and can choose and justify methods". In this sense orthopedagogy concerns a meeting or encounter between persons, a search for adapted methods and ethical positioning. Orthopedagogy is not only concerned with *disabled* persons (who may experience mental, physical or sensory impairments) but also with people who are deemed *deviant* (whose behaviour is seen as "difficult," "disturbed," "disordered" and which is caused by adverse social conditions, such as neglect, delinquency, drug abuse). The term was used for the first time in 1949 at an international congress in Amsterdam (Schoorl, 1997). Participants wanted to create a new scientific discipline and stressed

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its strict "educational" character. By combining psychiatric, developmental psychological and educational knowledge (Schoorl, Van Den Bergh, & Ruijssenaars, 2000), they strove to differentiate their approach from that of medically inspired *paedology* which saw the individual as a *sick organism.* At the same time they tried to move away from religious and ideological connotations of the previous term *heilpedagogiek* (Nijssen, 1942), and base their new discipline on humanist principles. Heilpedagogiek — close to the German Heilpädagogik — had a double meaning. It was used in Germany since 1861 and was based on the concept of curative intervention (Heilen-to heal) through pedagogical measures, or as a message of religious salvation (Heil / heilig-holy / holy-wholly; Bleidick, 1978). Orthopedagogy acquired the connotation *special* in Anglo-Saxon countries (special education) or *healing* in the Germanic countries (heilpedagogiek) or *disturbance-defect* in Russia (defectologie; Broekaert, 1997). From the 1970's, orthopedagogy developed practices (in accordance with influences in the Anglo-Saxon world), related primarily to its specialisms: *mental retardation* (Van Gennep, 1980), *physical* (Nakken & Loots, 1987) and *sensory impairment* (Van Uden, 1984), *learning difficulties or disorders* (Ruijssenaars, 1997), *behavioural problems* (Kok, 1986), and *substance abuse* (Broekaert, Vanderplasschen, Temmerman, Ottenberg, & Kaplan, 2000).

Since the nineties, the paradigm alteration in European thought was reflected by some "low country" — orthopedagogues, who promoted a change in approach.

The medical model saw the "disabled individual" as a group of symptoms with an organic basis (*impairment* within the International Classification of Functioning, Disability and Health, ICIDH, 2001) where the role of intervention was to "repair," "fix," "remedy" or "normalise" problems (Heshusius, 1995; Wolfensberger, 1980).

Thanks to the shift towards a social paradigm (Bayliss, 1998; Van Hove, Van Loon, & De Cuypere, 2001), the concept of *handicap* is seen as socially constructed, and relates to environmental conditions (including the social environment, broadly described as *attitudes;* Avramidis & Bayliss, 2000).

The orthopedagogical tradition has further moved away from classification, labeling and institutionalisation and now advocates the promotion of *basic rights* and *quality of life* for people with disabilities (Barnes, Mercer, & Shakespeare, 1999; Goodley, 1997; Oliver, 1996). The new orthopedagogy embraces ideas of *inclusion* (Daniels & Garner, 2000; Van Hove, 2000; Villa & Thousand, 2000), instead of *integration* and *normalisation.* It favours concepts of *empowerment* (Van Hove & Roets, 2000) and *self advocacy* (Dybwad & Bersani, 1996) of the disabled and supports social engagement. The *paradigm shift* in Ghent is in line with worldwide developments and orthopedagogy has aligned itself with changes in both thinking and practice. However it is not easy to implement a simple shift from the medical to the social model, from *remedy* to *rights* (Embregts, 2000). But despite criticism from traditional sources, influence of the new approach grows steadily and its concepts are appreciated by current policymakers (Van Gennep, 1999; Van Hove et al., 2001; Van Loon & Van Hove, 2001).

Integration of Paradigms

The paradigm-shift in thinking (Kuhn, 1970) challenged existing paradigms of knowledge. The dichotomy between the nomothetic and the interpretative paradigms that has driven *intervention* is no longer tenable.

The objective/realist position that describes the phylogenetic characteristics of normality that is used to define programmes of intervention has been challenged by the interpretivist/subjective response to the ontogenetic characteristics of the individual. The "tyranny of the normal" (Canguilhem, 1989), which understands *abnormality* as deviant or pathological, is no longer sufficient when posed against the subjectivist view which sees *difference* as ethically neutral.

However, for the practitioner, ethical neutrality creates individual ethical dilemmas and professionals should base a theory of action (intervention) on sound principles. If they fail to do so, vulnerable people in our society can be harmed through the good intentions of professionals who apply the "wrong theory" (whether or not this is either nomothetic or interpretative). We need a synthesis of the different (existing) paradigms and their train

to interventional practice (De Fever, 1994; Schoorl et al., 2000; Skrtic, 1995).

Man as Knowledge: The Empirical-Analytical Paradigm

The empirical-analytical paradigm strives for knowledge, clarity and explanation. It seeks to test statements of reality empirically and to test causal relationships between identified variables. It looks for objective and verifiable conclusions. Hypotheses are deduced and either accepted or rejected. One limits oneself to facts and to what can be corroborated. The tested knowledge then forms basis of the educational work and intervention becomes the application of universal statements to individual cases. *Knowledge* is thus constructed within a process of reductionism - factors relating to a particular syndrome, condition or pathology are determined and related to *developmental schemata*, which relate individual ontogeny to (empirically defined) classes. Thus, *discrepancy modeling* (Cole, Dale, & Mills, 1992) defines the process of intervention in that (objective) standardized measurements are used to "place" a child or adult within a conceptual space and which then determines the direction and rate of growth or development. This process led to "programmes of intervention," which exist independently of the child (and in many ways, independently of the professionals who apply such processes). The objective nature of reality inherent in this approach does not allow the child or adult to exist as a thinking, rational or social being: discernible behaviour is to be distinguished from consciousness and spirit, the starting point for projected change: "Man as knowledge."

This model leads to:

a) a science of special educational instruction which is based on a universal understanding of human behaviour (Kauffman, 1999);
b) remedial teaching and cognitive development through muscular movement and sensory training (Bladergroen, 1978);
c) cognitive training programs for learning disorders (Dumont, 1971; Ruijssenaars, 1997);
d) behaviour modification techniques and token systems to improve learning with the mentally retarded (Duker, 1989);
e) prediction and measuring of multiple risks of behaviour disorders in children and their social networks (Van Der Ploeg, 1990);
f) epidemiological research of behaviour disordered and emotionally disturbed children (Hellinckx, De Munter, & Grietens, 1991).

This paradigm is best represented by the categorizing of analytical assessment and practice, and in the many quantitative and statistical research developments in special education and medicine. It strives for objectivity. *Learning disabilities* or *behaviour disorder* is reified to become an independent ontological category that has validity and reliability, but does not relate to *person*. "*People* with learning disabilities," "*people* with drug dependency problems" have replaced the "learning disabled child" or "drug addict" in the discourse, but again, the category of problem is something that a person has. Once assigned to a category, the individual is subjected to a program developed for that particular target group. In order to support the objectification of deviance, deficit or disorder, a symptomatology is needed, which in turn requires a professional to apply the symptomatology within the boundary of what constitutes professional knowledge. Within this paradigm professional training (and the induction of the next generation of professionals) requires that students or practitioners assimilate the pre-given (objective) knowledge and demonstrate competence in applying it to individual cases according to the diagnostic-prescriptive process.

Man as Story: The Existential-Phenomenological Paradigm

In contrast, the existential phenomenological model strives towards meaningful action and understanding, not explanation. Man, as a subjective being with his own story, is situated in the meeting with the other, in the heart of existence. Essence of reality cannot directly be perceived, but manifestation of it, the phenomena, can be thoroughly interpreted and thus understood. Meeting with the other leads

to meaningful dialogue, action and self-fulfillment. The individual ontogeny does not recapitulate phylogeny; rather the "science of the singular" seeks to map an individual within his/her life-historical process where the concept of "problem" becomes a complex of interrelationships of subjective being. Validity and reliability are not issues within the subjectivist paradigm, and the paradigm does not seek universal application. The therapeutic process becomes (following the analytic tradition) an exploration of metaphor and symbol whereby *therapist* and *client* can reach an understanding of the *problem* and work towards a common goal of healing and growth. Developmental schemata or measurement do not determine this model. Here, orthopedagogy is seen as a process: "Man as story," and "Man as history."

This model leads to:

a) intervention, which can be considered as a human encounter; we have to listen to and try to understand the other (Langeveld, 1979);
b) expressive communication and imagination and priority of the educational/therapeutic relation (Van Gelder, 1953);
c) importance of touching, caring, living, eating, playing, learning, talking together, writing to each other etc. (Ter Horst, 1980);
d) humanistic education and psychology, educational strategies of trust, working in group and individual treatment (Kok, 1986).

This paradigm is best represented in psychoanalysis, the new school movement and the action oriented orthopedagogy. It applies to the modernist period in qualitative research and integrates quantities in qualitative approaches. It strives for subjectivity, and considers it as enlarged objectivity.

Man as Justice: The Critical Paradigm

The critical orientation strives for social justice and believes that structural intervention is a condition necessary to attain this. Language and thought are considered social products. There is a connection between thought and action, between achievement and science, practice and theory. Human labour leads to emancipation and discourages alienation. Man must free himself from these social structures and institutions, which are detrimental to his development, and strive for the well being of all. Man as an individual is entitled to human rights, emancipation and empowerment "Man as justice."

This movement leads to:

a) fair rights of the weakest (Barnes et al., 1999);
b) de-institutionalisation (Van Loon & Van Hove, 2001);
c) self-advocacy (Garner & Sandow, 1995);
d) inclusion (Zollers, Ramanathan, & Yu, 1999);
e) empowerment, and Quality of Life (Brown, 1998; Schalock, 1990).

The critical paradigm starts from the *social model* of disability (Van Hove & Roets, 2000). This model does not deny the existence of individual restrictions (impairments, or the loss or poor performance of a part of the body or a function of the body), but emphasizes the environmental and social barriers that contribute to society's interpretation of *impairment.* If the critical paradigm sees "Man as an ethical being" with his/her civil rights, this vision can influence the way in which orthopedogy and special education are seen. Intervention revalues *curriculum access* and *differentiation,* which entails adapting educational processes to meet individual needs. The critical paradigm is forcing rethinking about allowing access for previously barred individual children access to ordinary schools and providing them with support. A recent upsurge of parents demanding inclusive education for their children, together with changes in Belgian law, which now grant personal budgets for parents of children with significant disabilities, is increasing number of children in ordinary settings. This trend is changing the professional role of the *orthopedagogue* away from rehabilitation and remediation, towards support. These trends have to be understood in an international context where for example United Nations with their Standard Rules and UNESCO with its Salamanca Statement offer global frameworks that support the human rights discourse.

This paradigm has its critics within the field of special education for "denying" disability (Kauffman & Hallahan, 1995; Nakken, 2000; Vlaskamp, 2000) saying that a discourse of rights is not applicable for people with severe and multiple impairments. They state that the critical paradigm has been translated into legal and economic terms, but has little impact in social terms. This group of people is seen as being heavily dependent on care and the above cited authors fear that this new paradigm demands conditions for this group that cannot be realised. (Nakken; Vlaskamp). Other authors (Reinders, 2000) go further and propose the view that because societal conditions are inherently antagonistic to people with disabilities, the social model needs to be treated with caution in extending a *full* range of rights to the disabled minority. They state that ordinary social environments offer this minority group little opportunity for participation. If existing societal conditions do not, of themselves, offer full participation, then the critical paradigm must focus on the concepts of *relationships* and *community* which underpin the inclusion paradigm (Bogdan & Taylor, 1989; O' Brien & O' Brien, 1993; Taylor & Bogdan, 1989; Van Gennep & Van Hove, 2000).

If we apply the critical paradigm to the question of professional development, the focus for orthopedagogy moves towards supporting the growth of knowledge within the field of society and the nature of institutions. The shift away from objective knowledge of impairment towards understanding social environments requires a different knowledge base.

A Post-modern Critical Quality of Life and Human Rights Paradigm

International developments in the field of *disability* or *difference* have led to different conceptions of what constitutes the core elements of the discipline. Orthopedagogy takes as its focus the concept of "improvement through educational practice" and seeks to establish processes and procedures based on in-depth understanding of the child. Special education in the form advocated by Kauffman (1999) is based on a science of instruction, which in turn is based on a universal science of behaviour. This positivist stance has been severely attacked by adherents to the concept of inclusion, which proposes understanding complex systems through the application of postmodern, constructivist/deconstructionist theories.

Disability studies take as its premise that it

a) "crosses academic boundaries and draws on a variety of disciplines, including philosophy, sociology, psychology, history, anthropology and technology in order to analyse issues concerning the relationship between disability, social justice and political understanding" (Johnstone, 1998, p. 1), and:
b) "People working in the field of disability are articulating and theorizing a political, social and ideological critique (and who place) disability in a political, social and cultural context, that theorizes and historicizes deafness or blindness or disability in similarly complex ways to the way race, class and gender have been theorized" (Davis, 1997, pp. 2-3).

The different conceptualisations of what should be done for children with learning and developmental needs are only partial in their analyses. We argue for a synthesis based on holistic views, which can understand *and* explain the nature of "special" education. The rise of inclusion as a way of thinking about the role of schools and institutions and ways in which they can meet, range of children's needs. This has challenged existing paradigms of theory and practice. As we enter the postmodern age, the challenge is to develop a theory and practice which can meet the needs of the individual child and place him or her within an educational context creating the opportunity to participate in the community and become an integral part of it (Bayliss, 2000). This locates professional development within a changing field and we would argue that this requires that role of the specialist change from a direct provider of expert knowledge to one of consultant. This is because

> "the knowledge required for a teacher to educate all students with special needs in his or her classroom without the benefit of consultation from specialists is clearly beyond the bounds of professional capacity. A

> teacher supporting students with special needs may be required to implement instructional programmes to address social competency, specific learning disabilities, gross and fine motor habilitation, emotional adjustment, vocational readiness and challenging behaviour" (Littlejohn, 1998, p. 491).

As well, a teacher may be required to "understand the socio-cultural context of the inclusive classroom or institution which can support the understanding of 'philosophy, sociology, psychology and history, in order to analyse issues concerning the relationship between disability, social justice and political understanding" (Johnstone, 1998, p. 1). It is here, where philosophy meets the logistics of implementation/intervention that the development for future systems of professional development will tend.

These changes are reflected within the Department of Special Education at Ghent, and we would like to present a brief history to show how the paradigm-shift has worked within our institution.

The Ghent Application

In 1936, Nijssen, (a psychiatrist) was appointed to The Higher Institute of Education at Ghent University and charged with the "medical and educational treatment of abnormal children." He had been the adjunct physician of the well-known "State Colony" for the "mentally disturbed" in Geel — one of the oldest psychiatric institutions in Europe. Since the Middle Ages, this hospital offered foster family treatment. In 1942, Nijssen, together with his assistant Wens (a pedagogue), started a consultation unit for children and adolescents at the university (Broekaert, D'Oosterlinck, & Bradt, 1993). At the height of the war, he published a textbook on child psychiatry and special education (Nijssen, 1942). Nijssen's study was a classic medical work, based on categorical thinking and classification of "illnesses." He was influenced by sensorialism. His work drew attention to the psychiatric treatment of children at a time when Nazi's generally prosecuted psychiatric patients and disabled people.

Nijssen's successor, J. De Busschere, assumed the chair in 1946. He expanded the consultation unit (1964-1973) with a "medical - educational" observation day centre and a school for approximately fifty children aged between three and fourteen, with emotional and behavioural problems (Broekaert et al., 1993). In contrast to his predecessor, he had a psychoanalytic background and was interested in clinical neurology. Although he published work on the relative importance of the analytic perspective in treatment of difficult children, he was the leading neuro-psychiatrist of the university, and was aware of the phenomenological tendencies in psychiatry. It was the pedagogue Wens who assumed daily responsibility for the care service and development of student courses on children.

In 1970, Wens was appointed to the Faculty of Psychological and Educational Sciences. She became the first director of the Department of Orthopedagogics. As a former schoolteacher, she had been trained by the Dutchman K. Boeke — a Quaker — and a well-known member of the International Movement on School/Educational Reform. Both of them were active promoters of the *New School Movement* and both strived for active and global education to further the interests of the children. Under her leadership, the medical approach to children with learning problems, or emotional and personality disorders changed into an educational approach and *orthopedagogy* became an independent department at the university, catering for some sixty students at master's level (licentiate) enrolled in a three year study programme. The Observation Unit changed into an "Orthopedagogical Observation and Treatment Centre" that also functioned as a training centre for students (Broekaert et al., 1993). Most of the publications of Maria Wens were concerned with The New School Movement (Wens & Coster, 1950). At the same time, she was director of one of Belgium's largest institutions for children with behaviour disorders. During the eighties this large institute was the focus of major institutional conflicts; it became decentralized after periods of staff strikes and Wens had to leave the institution.

In recent years some interesting changes have taken place. The university department significantly increased its number of students (e.g., around 200 students at master's level

over the three years). The "Orthopedagogical Observation and Treatment Centre" became an independent unit with privileged links to the university. It cares for some seventy children with major behavioural problems. The care remains special but there is much more outdoor treatment, crisis and family interventions. A second centre for consultation, orientation, accompanying and training of some fifty disabled adults was inherited. Both centres serve as training units for the students. Two professors were appointed. The first, also first author of this article, specialized in behavioural disorders and substance abuse. He founded a drug free therapeutic community based on self-help and social learning. Under the influence of new managed care, it developed into integrated treatment systems. He has published extensively on that topic in the tradition of modernist, descriptive, historical and qualitative research (Broekaert et al., 2001). The second, also second author of this paper initiated the supervised independent living movement in Flanders. He favours disability studies and de-institutionalisation and publishes on current policies (Van Hove & Schelfhout, 2000) concerning that topic in the post-modern subjective, qualitative tradition. The study program of the students is based on a balanced interaction between behaviour disorder, substance abuse, and disability studies. The directors of the centres play a more independent role.

Changes mentioned above were also reflected in the curricula of the students. Before 1945, there were only two courses; one on 'psychiatry of abnormal children," the other on "medical educational treatment." Later, the courses gradually changed from a *medical* towards an *educational* perspective. However, it wasn't until 1964 that the departments of neurology, psychiatry and orthopedagogy were separated. From then on, the education of children with intellectual and character problems became the central point. Partial learning disorders (indicating that there is a discrepancy between the global intellectual possibilities and some partial defects) became part of the program. Attention was paid to the ethical aspects and practical training challenges theory. Psychology remains an integral part of the educational sciences. By the eighties, the post-graduate program was fully developed (after bachelor in psychology and education). It is now an independent specialty in the faculty (separate from pedagogy, social agogy, clinical, industrial, and experimental psychology). Theoretical and organizational orthopedagogy develops and underpins the educational action with children in problematic situations. Attention is now more focused on the action than on the disorder. Medical and psychological courses are fully integrated and attention is paid to diagnosis and treatment. Over the last ten years, the educational and psychological sciences developed separately and orthopedagogy is more connected to teaching and social sciences. As far as the theoretical and practical aspects are concerned, attention is focused on research (mainly qualitative). Within the department further specialties develop and attention is paid to substance abuse, behavioural problems and disability studies.

Discussion

During the many years of the department's experience, there has never been one all-encompassing theory that covered all aspects of care. Theory and practice were permanently reflexive in that clinical experience from clinical application (as part of the department's daily activities) informed theoretical understanding and vice versa. Over a period of time clinical diagnosis and observation in day care centers was replaced with work. This took place in both decentralised and specialised institutions and was combined with ambulatory and family work. This trend reflected the international trend/policy of de-institutionalisation for people with disabilities. The discipline changed from medical to educational. There was a transition from individualised pathology and remediation towards teamwork, self-help and emancipation. Theoretical orientations shifted from the classic medical empirical-analytical paradigm to a psychoanalytic phenomenological approach, and in later years towards a global child-oriented action approach, embedded in phenomenology. Last but not least, orthopedagogy has adopted a post-modern critical quality of life and human rights paradigm.

In that sense orthopedagogy connects with the position of Kunneman (1994) who states

that: "the science of orthopedagogy embodies an interesting and fruitful casus to analyse the changed position and epistemological status of the social sciences in the postmodern situation. Broadly speaking these changes concern firstly the relinquishment of the notion of an objective social reality, and secondly that the rationality of the practical interventions undertaken by the social sciences depends first and foremost on the truth of the knowledge legitimating these interventions" (Kunneman, 1994, p. 104).

The department has always conducted research, and the process of research followed the changes noted above; research was always empirically based but has changed from classic objectivist methodologies and methods, to modernist grounded qualitative methodologies, which embrace postmodern subjective and intersubjective orientations.

Since its inception, orthopedagogy in Ghent has followed humanist and systemic (or holistic) intervention methodologies that reflect the quest for social justice. Rigorous behaviourist conditioning was never adopted. Orthopedagogy changed from taking care of the weakest to empowerment and self-advocacy of people with disabilities. It often entailed struggling against the alienating aspects of society and against explicitly economically based managed care systems. The process of de-institutionalisation was a difficult one but became accepted. In fact there was never a real conflict between special education and disability studies, but a need to balance and differentiate between the two.

Conclusion

The post-modern agenda, which denies existence of a "grand narrative" of one all-encompassing theory has been a lesson learnt through experience at the Department (Bohm, 1985, pp. 32-33); the search for a global, whole or integrative theory remains an illusory task. There are many forms of holism (Apostel, 1992, p. 125). All-embracing theories do not exist, but insights taken from different theories can help us — which is not to suggest that education, care and support for people with disabilities should proceed in an eclectic fashion. Indeed, as we have argued above, that it is the dynamic and methodical nature of orthopedagogy, which differentiates it from special education; different theoretical positions need to be integrated to provide a model of intervention (and more importantly to provide understanding when *not* to intervene). In this sense, *disability*, *person*, *community*, *society*, and *knowledge*, *experience* and *justice* cannot be considered on their own, but are interdependent and transactional (cf. Wielemans, 1993). Rucker describes this process of integration (Rucker, 1986) in terms of complementarities. The competing paradigms alternatively complement each other and, at the same time, exclude an alternative interpretation of reality. The dynamic and interdependent transactions between different positions approach can be seen as an inaccessible synthesis, which in its turn includes its own anti-thesis and a new move towards synthesis. It is important to understand that parts and totality are in permanent organic interaction. In a sense the parts compose the totality, and the totality the parts. This occurs simultaneously but with individual qualities. As a "unity which is the unity of a multiplicity," (Plato) or as "The Beautiful in which the many is still seen as many becomes one" (Coleridge). The search for globality includes relativity and uncertainty, but can include a belief in the future. This change from certainty to uncertainty is acceptable if we understand that the goal of education, care and support has shifted from the certainty of *cure* to the uncertainty of *improvement*. Improvement is defined for an individual or group, within a specific context at a particular socio-cultural/historical moment — the direction and processes for change are predicated according to an analytic understanding of the complex interrelationships as they pertain in any given case. Such knowledge can only ever be partial — we learn by our mistakes and successes. Experience can be defined as intellectual and physical effort and emotional encounter acquired during the fulfillment of daily tasks. This experience can be further explained (objectivist) or understood (subjectivist) by theory, but caregiver (and student) must understand that experience inevitably remains incomplete.

Thus, pedagogues' attempts to develop a model of reflective daily action in the search for a solution, does not assume generalising

overtones. The solution pertains to the given socio-cultural and historical context. The caregiver has to make ultimate, sometimes impossible decisions and accept professional responsibility for those decisions. Professional responsibility (and its development through training) rests on one understanding that the object of study is unknowable in any finite way and that there is no "one answer." The professional and aspiring professional must subscribe to "open-mindedness:"

> "Open-mindedness is a willingness to construe knowledge from a variety of perspectives without loss of commitment to one's own values. . . . It asks that we be accountable for how and what we know, but it does not insist that there is only one way of constructing meaning, or one right way. It is based on values best suited to deal with the changes and disruptions that have become so much a feature of modern life. (Bruner, 1990, p. 30)

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