

Thinking about Disabilities in a Primary Inclusive Education Class in Vietnam

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Keywords disabilities, attitudes, thinking, perceptions, conceptions, children, Inclusive Education, Vietnam, Southeast Asia, Minor Field Study
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Abstract

This Minor Field Study was undertaken in the outskirts of Hanoi, Vietnam during September and October 2003. The aim was to explore what 10-11 year old primary school children think about disabilities in an Inclusive Education class, i.e. a class with non-disabled children and children with disabilities (CwD). Sixteen children, including four CwD, were interviewed in a semi-structured way. The children mentioned physical disabilities more often than “mental” or “learning” disabilities even though three of the CwD had those kinds of disabilities. More than half the sample seem to think about war-related causes of disabilities. Many interviewees also mentioned that other children treat CwD both “well” and “badly”. Some girls and no boys mentioned that they feel sympathy for and want to help persons with disabilities. One-fourth of the children seem to think of disabilities as a deviation.

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Johan Bergstad and Johan Granli

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THINKING ABOUT DISABILITIES IN A PRIMARY INCLUSIVE EDUCATION CLASS IN VIETNAM

The United Nations (UN) Convention on the Rights of the Child, Article 2 stipulates that children with disabilities (CwD) have the same rights as other children (Hammarberg, 2002). They have the right to live under circumstances that support their self-confidence and active participation in society (Article 23). Article 28 states every child's right to education. This right is mirrored in Education for All, a term introduced 1990 at the World Conference on Education for All in Thailand (Lindskog & Nguyen, 2002).

A part of Education for All is Inclusive Education, which means that CwD are included in the mainstream school instead of placed in special schools (Hill & Rabe, 1994; Jönsson, 2000; Ta, 2000). Inclusive Education is practised in many countries all over the world, for example in Vietnam where it has been implemented to the furthest extent of all the countries in South and Southeast Asia (J. Runholm, personal communication, 11th March, 2004).

An important part of the implementation of Inclusive Education is the non-disabled children's attitudes toward CwD (Le, 1999; Lindskog & Nguyen, 2002; SOU, 1998; Ta, 2000). Positive attitudes, for example acceptance of the CwD, seem to support that these children are socially included instead of excluded in the school class (Le, 1999; Lindskog & Nguyen, 2002; Tamm, 2001). Attitudes consist of emotions, behaviour patterns and thinking (Bruzelius & Skärvad, 1995; Diamond, 1993; Le, 1999; SOU, 1998; Ta, 2000; Tamm, 2001). The relations between the three components are however very complex; one can for example think in one way and act in another, which means that attitudes are difficult to investigate (SOU, 1998; Tamm, 2001).

Children's thinking about disabilities is relevant to study because it can be crucial in the process of forming attitudes toward CwD (Bierman, 1997; SOU, 1998; Tamm, 2001). Since there is a lack of research on children's thinking about disabilities in Vietnam (Huff, Maarse & Lancaster, 2003) we chose to focus on thinking, or more specifically on conceptions of disabilities (Solso, 2001; Tamm, 2001). A step in the process of changing children's thinking about disabilities can be to produce more knowledge of that issue (SOU, 1998; Tamm, 2001). The aim of this study is therefore *to investigate what Vietnamese primary school children, in an Inclusive Education class, think about disabilities.*

Theoretical framework

The theoretical framework is divided into definitions of thinking and disability and international as well as Vietnamese findings on children's thinking about disabilities. This chapter ends with information about Vietnamese school children's education, which is a part of the context where the study was carried out.

Thinking defined

There are many definitions of how to understand the concept of thinking (Alerby, 1998; Helldén, 1994; Lundh, Montgomery & Waern, 1992; Solso, 2001; Wood, 1999), and the concept has been explored and defined differently within the disciplines of philosophy and psychology (Alerby, 1998; Lundh et al., 1992; Solso, 2001). Philosophers frequently define thinking in wide terms such as "all spiritual activity" or "all consciousness" (Alerby, 1998, p. 40). The present study is written within the field of psychology, where thinking in contrast to the philosophical meaning is considered as a demarcated part of the consciousness. Still, thinking is a complex process that includes a wide range of cognitive activities, such as perceiving, concluding, analysing, reflecting and associating (Alerby, 1998; Eysenck & Keane, 2001; Lundh et al., 1992; Solso, 2001). Solso (2001) describes thinking as "the crown jewel" of cognitive psychology and he defines thinking as "a process by which a new mental representation is formed through the transformation of information by complex interaction of the mental attributes of judging, abstracting, reasoning, imagining and problem solving" (p. 417).

Furthermore, thinking can be divided into process and content (Wood, 1999). The content of thinking can for example consist of conceptions, i.e. ideas or perceptions about a phenomenon (Solso, 2001; Tamm, 2001; Wood, 1999). Cognitive psychologists sometimes also use the terms mental representations or schemes to describe the content of thinking (Eysenck & Keane, 2001; Lundh et al., 1992). Mental representations can be defined as mental images or as an internal language of the mind (Eysenck & Keane, 2001; Lundh et al., 1992; Solso, 2001). Researchers (Diamond, 1993; Diamond & Hestenes, 1996; Lundh et al., 1992) state that mental representations are critical for both children and adults in the forming of generalised beliefs about others, i.e. categorisations or stereotypes about for example disabilities. Stereotypes can be defined as over generalised and simplified schemes or conceptions that we unconsciously use to categorise other persons in order to deal with complex phenomena and to make predictions about future events (Lundh et al., 1992; Tamm, 2001). Negative stereotypes can also be called prejudices, and in the case of CwD these

prejudices can imply that they are inferior, incapable of taking care of themselves and in need of help and compassion (Tamm, 2001). Children often form this kind of negative thinking about disabilities at the age of five or six years (SOU, 1998).

Disability defined

There are many definitions of impairment, disability and handicap (Färm, 1999; Hjelmquist, Rönnerberg & Söder, 1995; Jönsson, 2000; Kebbon & von Stokkom 2000). Several researchers (Bickenbach, Chatterij, Saxena, Trotter & Üstün, 2001; Ingstad & Whyte, 1995; Kisanji, 1999; Stiker, 1999) have also shown that the concept of disability, including the way people report causes of disabilities, vary across cultures. For example, a common perception in “Western” societies such as USA is that disabilities are caused by medical factors, whereas people in Southeast Asia sometimes seem to think of disabilities as a punishment for bad moral behaviour in a previous life (Kim, Sadana & Sek, 2001).

One attempt to design a universal definition is the World Health Organisation’s (WHO) definition of disability (WHO, 1998). In this definition impairment (organ level) is described as a loss of body structure or of a physiological or psychological function, for example loss of limb or loss of vision. Disability (individual level) can be seen as a reduced or absent ability to perform actions as a result of impairment. A person can be described as handicapped (social level) when s/he cannot take a part in mainstream community life on an equal basis or fulfil a role that is considered “normal” by many of the community members (SOU, 1998; WHO, 1998). The WHO (1998) definition has been subjected to criticism for its pretension of being universal, when it in fact can be seen as a “Western” construction (Barnes, Mercer & Shakespeare, 1999; Ingstad & Whyte, 1995).

The Parliament of Vietnam (1998, in Huff et al., 2003) defines disability as a lack of “one or more body parts or functions reducing the capability of action and causing difficulties in work, life and study” (p. 20). However this definition is not widely disseminated to the local administrative level (Lindskog & Nguyen, 2002). For example, CwD are often labelled as “children in difficult circumstances” (Björk, 1997, p. 2; Ta, 2000, p. 7). Other groups in this category are children from poor families, children of ethnic minorities, working children, orphans and street children (UNICEF, 1990; Vu, 1996). In several districts of Vietnam, for example Cai Lay, there is a movement to change the classification system for disabilities (Lindskog & Nguyen, 2002). In Cai Lay district prior to 1998 CwD were grouped into 40 different categories, and for example “broken finger” was classified as a disability. Since 1998 the classification system in that

district consists of seven groups, including “strange behaviour”, moving difficulties, seeing difficulties, hearing and speaking difficulties (Lindskog & Nguyen, 2002).

Children’s thinking about disabilities internationally

Most of the research on thinking about disabilities has been performed in USA (Ingstad & Whyte, 1995; SOU, 1998). Many researchers (Holzer, Vreede & Weight, 1999; Ingstad & Whyte, 1995) state that culturally specific assumptions often are implicit in scientific analyses and that cross-cultural studies of disability should involve consideration of its cultural construction in “Western” societies. The studies referred to in this chapter are carried out in a “Western” context. “People” or “persons” in the referred research include both children and adults.

Tamm (2001) states that children sometimes have ambivalent thoughts and feelings when they meet persons with disabilities. On the one hand they can think of disabilities in negative terms and on the other hand they can feel sympathy for and a will to help those persons. Research (SOU, 1998; Tamm, 2001) shows that there can be different thinking about different disabilities. For example, Andersson & Lawenius (1989, in Lawenius, 1998) found that 11-16 year old Swedish school children were more tolerant of physical disabilities than of a mental retardation like Down’s syndrome. This is confirmed by Westbrook et al. (1993, in SOU, 1998) who state that persons with for example heart disease are more accepted by children than persons with mental retardation. Other research (SOU, 1998) has shown that children’s thinking about persons with so-called mental disabilities often is negative and prejudicial, whereas people who are blind sometimes are regarded as inferior and in need of help and sympathy. Still, Persson and Sköld (1995, in SOU, 1998) state that also children who are blind often are isolated.

Many researchers (Diamond & Innes, 2001; Hill & Rabe, 1994; Lawenius, 1998) have found that children’s conceptions of mental disabilities can be age-related. Seven-year-old-children can for example have difficulties in perceiving and describing mental disabilities, which is not the case with children 11 years and older (Lawenius, 1998). Besides, children tend to rate children with mental disabilities as less competent also in other competence domains, such as language skill and physical ability (Diamond 1994, in Diamond & Innes, 2001; Hill & Rabe, 1994). This is not the case with children with physical disabilities, who often are judged as less competent only within the physical competence domain. Younger children sometimes may use concrete features to explain what it means to have a disability, for example “she’s got a thing in her ear”

(Carpenter, Diamond, Hestenes & Innes 1997, in Diamond & Innes, 2001). This can, according to Diamond (1993), explain why younger children have considerable difficulties in perceiving mental retardation.

Studies (Diamond & Innes, 2001; Hill & Rabe, 1994; Nordström, 2002; SOU, 1998; Tamm, 2001) on Inclusive Education classes show that non-disabled children’s thinking about disabilities can be related to the frequency with which they have contacts with CwD. Researchers (Carlson, Helmstetter & Peck, 1992, in Diamond & Hestenes, 1996; Tamm, 2001) have found both that the non-disabled children can become more accepting with fewer negative stereotypes about CwD, and also that they can develop more negative stereotypes about those children. According to Tamm (2001) CwD in Inclusive Education classes often meet social barriers, i.e. they seldom participate in games, are often teased and have few friends. Boys seem to tease CwD more often than girls (ibid.). Children can for example tease these children verbally in statements related to the disability, or more physically by pushing them (Tamm, 2001). Cameron and Spitzer (1995, in Lawenius, 1998) state that girls are more tolerant of deviant behaviour than boys, something that is also confirmed in a study by Prellwitz & Tamm (2000, in Tamm, 2001).

Disabilities in Vietnam

When examining statistics of disabilities in different districts of Vietnam there are often inconsistencies related to classification issues and inaccuracies in the research methods used (Bierman, 1997; Huff et al., 2003; Ta, 2000; UNICEF, 1990). The prevalence rate of persons with disabilities in Vietnam for 2003 was estimated to 6.3 % of the population, i.e. 5.1 million persons (Huff et al., 2003). As seen in Table 1 the four most frequent disabilities for persons in Vietnam are mobility disabilities, mental/intellectual disabilities, hearing and speaking disabilities and visual disabilities (Huff et al., 2003).

Table 1
Persons with disabilities in Vietnam by type of disability (National Statistic Data Collection, 2003, in Huff et al., 2003)

Type of disability	Percentage (%)
Mobility disabilities	29
Mental/intellectual disabilities	24
Hearing and speaking disabilities	16
Visual disabilities	14
Other disabilities	17

The prevalence rate of CwD (0-18 years) is estimated to be 2.4 % of all the children in Vietnam, i.e. 660 000 children (Huff et al., 2003). This figure is much smaller than the 1.2 million CwD estimated by Vietnamese ministries (in Huff et al., 2003). According to statistics from the University of Pedagogy in Hanoi (1998, in Lindskog & Nguyen, 2002) the most common disabilities for CwD are learning disabilities, physical or moving disabilities and seeing disabilities (see Table 2). It is also common that children have multiple disabilities (Huff et al., 2003).

Table 2

Children with disabilities in Vietnam by type of disability (University of Pedagogy in Hanoi, 1998, in Lindskog & Nguyen, 2002)

Type of disability	Percentage (%)
Learning disabilities	27
Physical or moving disabilities	19
Seeing disabilities	12
Other disabilities	42

Causes of disabilities in Vietnam are for example infections and diseases, inadequate medical and natal care, hereditary factors and accidents (Bierman, 1997; Huff et al., 2003; Lindskog & Nguyen, 2002; UNICEF, 1990). For example, nutritional deficiencies can cause seeing disabilities and over-prescription of streptomycin can cause hearing disabilities (Bierman, 1997; Lindskog & Nguyen, 2002; UNICEF, 1990). Researchers (Bierman, 1997; Huff et al., 2003) state that diseases and congenital birth defects are the two most common causes of disabilities in Vietnam. The war between Vietnam and USA between 1961 and 1971 has also caused many disabilities, both during the war and afterwards (Bierman, 1997; Lindskog & Nguyen, 2002; UNICEF, 1990). More than one million Vietnamese persons died during the war and about ten million of the survivors are classified as “war-victims” (Bierman, 1997). Soldiers and citizens became disabled by bombs, mines, shooting and also toxic chemicals that USA spread in southern Vietnam (Bierman, 1997). USA spread 70-140 million litres of the herbicide Agent Orange, that for example has caused lung cancer and leukaemia amongst soldiers exposed to it (Schytt, 2003-11-03). Some of the long-term effects of Agent Orange can be congenital malformations in all parts of the body, anomalies of the neurological system and paralysis (Bich, Bui, Le & Quoc, 1994; Fukuhara et al., 1994; Schytt, 2003-11-03; Ta, 2000; UNICEF, 1990). According to Wen Ting Ha Foun, head of the University Hospital in Ho Chi Minh City (in Schytt, 2003-11-03), 4 % of the mothers of malformed babies have been exposed to Agent Orange. Agent Orange contains

dioxin, which is toxic and is absorbed from food and transmitted from mother to baby through breast milk (ibid.).

One way to classify disabilities in many cultures is to divide them into those caused by oneself, those caused by others, and those caused by fate or by God (Bierman, 1997). In Vietnam, for example Buddhism and Confucianism are important religions (Luong, 1992; Pham, 1999; Rydstrøm, 2003). Confucianism is further discussed in *Vietnamese school children's education* below. According to the Buddhist concept of karma good deeds have good effects for a person whereas bad deeds have bad effects, both for this and the coming lives (Bierman, 1997; Luong, 1992). Consequently many people in Vietnam, according to Bierman (1997), consider disabilities to be a result of a person's bad deeds in previous lives. This traditional way of considering disabilities can lead to a tendency of family members of the CwD toward embarrassment and attempts to hide these children (ibid.). Another reaction can be that the child is perceived as carrying the family's burden, i.e. that the family atones its crimes by having a CwD, and that he or she therefore must be protected against all evil (Alfredsson, 2001; Bierman, 1997). In both cases, the CwD is often isolated. In spite of this traditional way of looking at the causes of disabilities, a recent study (Huff et al., 2003) shows that people in Vietnam nowadays generally do not seem to think that persons with disabilities have done something to deserve their situation, or that parents of CwD previously have done something bad. According to Ta (2000) people's awareness of causes of disabilities in Vietnam generally is quite limited.

Researchers (Bierman, 1997; Le, 1999; Lindskog & Nguyen, 2002) state that in general there is one positive and tolerant way to think about disabilities in Vietnam, and one negative way often based on fear. The positive thinking is for example expressed as acceptance, kindness and sympathy (ibid.). Sometimes peers and other people in the local community perceive a CwD as an "ordinary" child, only with a specific problem (Alfredsson, 2001; Huff et al., 2003). Ta Thuy Hanh at Save the Children Sweden in Vietnam (in Alfredsson, 2001) mentions that peers sometime help their classmates with disabilities to school and that their former isolation is dissolved. One-third of the CwD in Huff et al.'s study (2003) report that they themselves have experienced kindness and sympathy. Huff et al. (2003) collected data from three provinces and found that about 90 % of the 133 respondents (CwD, parents of those children, teachers in special and Inclusive Education classes and other community members) think that persons with disabilities should be respected and treated like everybody else. Still, the same authors found that more than half of the CwD did not have any friends. Especially children with "strange behaviour" and intellectual disabilities were in lack of friends (Huff et al., 2003). Le (1999) states that some non-disabled children tease CwD and that some CwD do not play with other

children during breaks. According to Huff et al. (2003) common words and expressions used to describe CwD in Vietnam are “bad temper”, “feeling of inferiority”, “feeling sorry for themselves”, “not smart”, “failure”, “unhappy” or “unfortunate” (p. 90). Also, these children often seem to be perceived as unhealthy, weak and in need of help and charity (Bierman, 1997; Huff et al., 2003; A. Maarse, interview 4th September, 2003). Researchers (Bierman, 1997; Le, 1999; Ta, 2000) have found that persons with disabilities often are pitied, overprotected, perceived as “deviant”, and also state that the negative conceptions of those persons can contribute to their isolation and dependency on others.

Vietnamese school children’s education

Historically, Vietnam has had a strong movement for learning and teachers have been part of the local authority (Lindskog & Nguyen, 2002; Lopez, 1995; Rydstrøm, 2003). Compared with other Southeast Asian countries Vietnam’s population of nearly 81 million is well educated (Huff et al., 2003; Vu, 1996). Although university education is out of reach for most Vietnamese, the country’s literacy rate is high (90-95 %) (SIDA, 1998; Ta, 2000; Vu, 1996). The Vietnamese compulsory school system comprises 12 years divided into Grades 1-5 (primary school), Grades 6-9 (lower secondary school) and Grades 10-12 (upper secondary school) (Ta, 2000; Vu, 1996). Children normally start school at the age of six. The content of education in the primary school is for example Vietnamese, mathematics, natural science, and morality (Lindskog & Nguyen, 2002). A priority is to teach school children acceptable behaviour; knowledge comes afterwards. This emanates from the ancient Confucian doctrine “First morality, then knowledge”, a concept widespread in Vietnamese education (Lindskog & Nguyen, 2002; Ngô, 2000; Rydstrøm, 2003).

Confucianism states that males are superior to women, and girls and boys are often taught to practice “good morality” differently, both at home and in school (Pham, 1999; Rydstrøm, 2003). Girls are expected to practice “tinh cam”, which can be translated as “feelings” (Rydstrøm, 2003, p. 52) or “feeling of solidarity, sympathy” (Kleinen, 1999, p. 209). Feelings in Vietnam can be described as a part of social competence or proper social actions rather than as an individual psychological phenomenon (Rydstrøm, 2003). Rydstrøm (2003) states that girls for example express “tinh cam” as a sensitiveness about “when to assist someone in need of help” (p. 52). Girls who lack this sensitiveness might be blamed for bad moral behaviour. Vietnamese boys’ “good morality” is instead linked to the patrilineage, which Pham (1999) describes as a cross-generation community consisting of both living and dead male relatives. Whereas girls

practice “tinh cam” boys rather fulfil their duties within their lineage (Kleinen, 1999; Luong, 1992; Pham, 1999; Rydstrøm, 2003).

Many CwD do not complete primary school and they usually do not continue to secondary school (Huff et al., 2003; Lindskog & Nguyen, 2002). Vietnam has, as most of the world’s countries, special education for CwD (Jönsson, 2000; Ta, 2000). About 7,650 CwD attend 92 special education schools (Huff et al., 2003; Lindskog & Nguyen, 2002). Inclusive Education was initiated in Vietnam 1990 and is implemented by the Research Centre for Special Education (RCSE) of the Vietnam National Institute of Education Sciences (NIES), which is a part of the Ministry of Education and Training (MOET) (Lindskog & Nguyen, 2002; Ta, 2000). Approximately 30,000-40,000 CwD (about 5 % of the total number of CwD) study in 17,500 Inclusive Education classes (Huff et al., 2003; Lindskog & Nguyen, 2002; Ta, 2000). A part of Inclusive Education in Vietnam is to eliminate physical barriers for CwD, but also psychological barriers such as negative thinking about disabilities (Lopez, 1995). In many of those classes there is a so-called Circle of Friends consisting of a couple of the classmates who are expected to support the CwD during school time (Lopez & Ta, 2000).

Method

This study is explorative, since the intention is not to examine a hypothesis but to explore children’s ways of thinking and telling (Doverborg & Pramling Samuelsson, 2003). Several researchers (Doverborg & Pramling Samuelsson, 2003; Lantz, 1993; Silverman, 2002) recommend semi-structured or unstructured interviews for research that seeks to explore experiences, opinions or reasons. By utilising semi-structured interviews we could go deeper into specific answers when needed. The purpose of this data collection method is to receive varying descriptions that render the qualitative multiplicity of the phenomenon examined (Doverborg & Pramling Samuelsson, 2003). The present study wants to explore the unique parts by giving examples of the variation in the children’s answers. We also want to find common patterns in the children’s ways of thinking about disabilities. To investigate these patterns we accounted for the data quantitatively.

Selection

The contact person in Hanoi, Ta Thuy Hanh at Save the Children Sweden, mediated the contacts with the school authorities in a district in the outskirts of Hanoi. The school authorities suggested five primary schools where Inclusive

Education is practised. We selected the first listed alternative of these schools. In order to safeguard confidentiality the name of the school where the field study was carried out has been changed to *The Tieu Hoc School* (“Tieu Hoc” is Vietnamese for “small study”, i.e. “primary”).

The Tieu Hoc School is situated in the outskirts of Hanoi. The 790 students are divided in Grades 1 to 5, and according to the headmaster (personal communication, 17th September, 2003) the school has practised Inclusive Education since 1990. The 35 CwD are included in 19 classes. The headmaster categorised the children’s disabilities as “mental disabilities” and physical disabilities. She told us that most of these children had “mental problems”, which according to her often result in “learning difficulties”. The school also educated 36 CwD in two special classes in a nearby institution for children who were described by the headmaster as “victims of war”. The school did not receive any financial support from the government for the implementation of Inclusive Education but instead from the non-governmental organisation PLAN International.

The headmaster of *The Tieu Hoc School* described the class compositions where the numbers of CwD in the different classes were mentioned. She explained that all the classes in the school were available for the study. When we selected the class for this study our intention was to interview older primary school children (Grade 5) since they generally have more courage than the younger ones to converse with an adult authority (A. Maarse, interview, 4th September, 2003). Older children are also generally more verbal and can have a higher cognitive awareness (Arnqvist, 1993; Lawenius, 1998), meaning that it might be easier for them to communicate their thinking. These criteria were fulfilled in one of the classes, which we call *Inclusive Education Class, Grade 5*.

In *Inclusive Education Class, Grade 5* there were 33 students and four of them were said to have disabilities. We were told that three of the four CwD had “mental problems” but we received no further information about possible diagnosis. The fourth child had, according to himself and the class’ teacher (personal communication, 26th September, 2003), heart problem from birth. None of the non-disabled classmates were informed that those four children had some kind of disabilities. Also, the teacher had not participated in special training courses on how to educate CwD.

Group of selection

The 16 children (eight girls and eight boys) were 10-11 years old and were all selected from *Inclusive Education class, Grade 5*. Twelve non-disabled children were randomly selected, i.e. every second girl (six) and every second boy (six) were selected from the class list, which was listed in alphabetical order. Since

the non-disabled interviewees might come to think and talk about their classmates with disabilities we decided for ethical reasons to also include the CwD (two girls and two boys) in the sample and thereby give them the opportunity to express their opinions in the topic. One non-disabled boy did not want to participate and was therefore replaced by another randomly selected boy (the 13th boy in the class list).

Ethical aspects

Ethical considerations are of great importance when carrying out research with children, since the predefined inequalities in status between them and the researchers can make it difficult for the children to refuse participation (Beresford, 1997). The Swedish Council for Research in the Humanities and Social Sciences' (HSFR, 1999) ethical principles concerning information, consent, confidentiality and restricted use have been followed throughout this study. In order to follow these rules we first contacted Save the Children Sweden's Vietnamese partner organisation PLAN International and thereafter the headmaster of the school. They received the following written information about the study: *Interview guide* (see Appendix 1), *Introduction letter* and *To whom it may concern*. The latter contained information about the aim of the study and the ethical guidelines described by HSFR (1999).

The 16th September 2003 we briefly informed the children in the potential sample group orally about the study and also obtained their consent. This information was also given at the beginning of each interview. It was emphasised that participating in the study was voluntary and that the information would be treated confidentially (see *Interview guide*, Appendix 1). Informed consent was also obtained from the parents of the children in the class. This was done by giving them a letter in Vietnamese about the study that they were supposed to read, sign and send back to us (see *Letter to parents*, English version, Appendix 2). In this letter we informed about the aim of the study, that the interviews would be recorded and the recorded material destroyed afterwards. We also informed that the collected information would be treated confidentially, i.e. the children's real names would not be used in order to make it impossible for others to identify any child. The parents were also asked to inform their child about the study. We wanted the parents to tell their children because we thought it was easier for them to be informed in their own language; thus we were not sure that we could present the study in understandable terms for the children (Beresford, 1997). To secure confidentiality throughout the study personal or family names were replaced with B for boys and a G for girls plus a number (for example B1, G2 etc.) when transcribing the interviews.

Data collection

Preparations

Two group discussions were performed in half a class with the ambition for the children and for us to get to know each other better, but also to give further information about the study. Since none of us speak Vietnamese, two professional interpreters were contacted to help with translation from Vietnamese to English and vice versa during the interviews. Before the two pilot interviews were conducted, we informed the interpreters of the need to distinguish between open-ended and leading questions, and how that difference might affect the answers. During the period of data collection we continually assured that our questions were interpreted in a correct way as well as comprehensible for the interviewees. Wadensjö (1998) points out that the presence of an interpreter can change the content as well as the form of the communicative process. In order to reduce the risk of errors in translation we used short sentences.

Interview

Before each interview we were present during a break in the schoolyard, with the aim to watch the children's activities and thus become a more "familiar face" (Beresford, 1997). This gave an opportunity in the introduction to each interview to relate to what had happened earlier (Beresford, 1997; Doverborg & Pramling Samuelsson, 2003). The interviews were approximately 30-40 minutes long, recorded with Mini Disc recorders, and transcribed shortly afterwards. They were performed between the 16th and 26th September 2003.

The environment in which the data collection takes place can strongly affect children's ability to communicate, especially for CwD (Beresford, 1997; Doverborg & Pramling Samuelsson, 2003). Therefore we tried to arrange the interviews in a place where no other persons would disturb the interview and where the children could feel as comfortable as possible. This was not easy to achieve, since the school did not have any walls all the way up to the ceiling. Half of the interviews took place in a small building at one end of the schoolyard, and the other half in a small room in the main building that could be used temporarily for the study.

We tried as far as possible to only ask open-ended questions, which are to be used prior to leading questions when interviewing children (Cederborg, 2000). It is also necessary for the interviewer to adapt to the child's level of communicative abilities and that the researcher uses the child's own words, something that can support the child to continue his or her story (Beresford, 1997; Cederborg, 2000). This course of action is thought to reduce the risk of the interviewer influencing the child's answers, for example to get confirmed

answers (Hill & Rabe, 1994). Researchers who come from a different culture than their informants run the risk of imputing their own norms and values to the informants (Ryen, 2001). There is also a risk that the children might think that a question means something other than was intended (Alerby, 1998; Tamm, 2001), especially when the interviewers and the children are of different ages, have never met before and have different cultural backgrounds with differing value systems (Beresford, 1997; Ryen, 2001). There can also be a discrepancy between what one thinks and what one communicates to others (Alerby, 1998; Tamm, 2001), but researcher's (Alerby, 1998; Wood, 1999) state that people (including older children) usually can express their thinking and feelings to others. By interviewing a person one can, according to Lundh et al. (1992), get a picture of his or her thinking about a specific phenomenon. Huff et al. (2003), who investigated attitudes toward CwD in Vietnam, point out that "one has to take into account that Vietnamese children have a tendency to give 'socially desirable' answers, meaning answers that show a positive attitude" (p. 59).

Interview guide. The questions in the interview guide were developed in discussion with our tutors, the contact person in Hanoi and also other researchers in Vietnam. The first part of the interview guide consists of "Warm-up-questions", i.e. contextual questions, in order to facilitate the communication (Beresford, 1997; Cederborg, 2000) (see *Interview guide*, Appendix 1). The questions are about different types of interactions with classmates during the break before the actual interview was started. Since we usually were present during the break, these experiences were thought to work as a natural entrance in common, for example: "I saw that you were playing elastic band skipping ..."

The second part of the interview guide, "Thinking about disabilities", is directly linked to the aim of the study. The child's answer on the first question, "What disabilities do you know of?", was used to select what kind of disabilities the further interview should deal with. If the child did not have any suggestions of disabilities the interviewer changed the open formulated questions into more leading questions, such as "Can a seeing difficulty be a disability?" As soon as the child mentioned at least two names of disabilities the interviewer proceeded to the questions 11a–h, which were asked for each disability separately. The intention was not to ask these questions in order but rather to follow the interviewee's answers the way a natural conversation would. The 11a–e questions for example deal with how disabilities come into existence and how CwD are treated. Question 11a deals with thinking when meeting "somebody" with disabilities. The reason for not asking about children is that we of ethical reasons wanted to avoid discussing a specific child in the class and thus contribute to a labelling of the CwD (Hill & Rabe, 1994; Lindskog & Nguyen, 2002; Tamm, 2000). Also in question 11 f–h we of ethical reasons asked for the interviewee's experience of persons with disabilities and not CwD. The final

question, i.e. “Do you know of any other disabilities?”, was asked in order to catch eventual new names of disabilities that might have come into the interviewee’s mind during the interview.

Data analysis

Atkinson and Coffey (1996) state that creating categories is a first step to think about the data in a systematic way. The interviews were read several times with the aim of the study in mind. The reason for this first way of analysing was to obtain an overall picture of the interviews, but also to develop ideas about preliminary categories. We read the interviews separately and noted our thoughts and ideas about possible groups of data. These notes and ideas were then shared and discussed, which resulted in seven categories. These categories were then compared, in order to distinguish similarities and differences between the categories. This process led to the creation of two more categories; i.e. nine categories in total.

Parts of the text were cut out and placed in nine piles. We evaluated the material separately and it proved to correspond, i.e. there was an agreement regarding which sections were relevant for the nine categories and to which category they belonged. The nine categories proved to encompass a large part of the content of the material, which in turn gave support to the notion that the selected categories were appropriate and useful in order to illustrate the material. The final step of the analysis involved going through the nine piles of selected text material to look for patterns, themes and regularities as well as contrasts, paradoxes and irregularities within the categories. This led to the division of the nine categories into three main categories, which we call themes (see *Results* below).

Data presentation

Quotations are used to make it possible for the reader to judge the reasonableness of the interpretations. These quotations have been selected from all the interviews, but only the quotations that most clearly illustrate the category are presented. Information about the question that was asked is given in addition to the quotation. Sentences and words which have been judged as not necessary for understanding the results have been excluded and replaced with slanting lines, i.e. /.../. Text put in brackets, i.e. [text], is for example used to explain dialogue parts or give information about what kind of disability the child talks about. Furthermore, the children are numbered from 1 to 16 (“B1”, “G2” etc.). “INT” stands for Interviewer. In order to keep a high confidentiality throughout the study the CwD’s identities are not revealed. However, in some

cases we have found that it is important for the presentation of the data to know whether the statement comes from a CwD or not. In those cases we do not give the child's number, but instead writes for example "one of the girls with disabilities says ...". The interviewees' names of different kind of disabilities are written with apostrophes, for example 'blind' and 'something wrong with the brain'.

Results

The three themes that emanated from the data analysis contain nine categories that are supposed to give more detailed illustrations of each theme's structure. Table 3 shows this structure.

Table 3
Themes and categories emanating from the data analysis

Themes	Categories
1. <i>Meeting disabilities</i>	1. <i>Naming a disability</i> 2. <i>Recognising children with disabilities</i> 3. <i>Thinking and feelings when meeting persons with disabilities</i> 4. <i>Disability as a deviation</i>
2. <i>The nature of disabilities</i>	1. <i>Causes of disabilities</i> 2. <i>Disabilities' development and duration</i>
3. <i>The social treatment of children with disabilities</i>	1. <i>Children with disabilities' access to play</i> 2. <i>My treatment of children with disabilities</i> 3. <i>Others' treatment of children with disabilities</i>

Meeting disabilities

The four categories in this theme deal with different kinds of meetings between the child and disabilities. The first category, *Naming a disability*, can be seen as a meeting between the child and the term disability. The second category is about *Recognising children with disabilities*. In contrast to the third category, i.e. *Thinking and feelings when meeting persons with disabilities*, the last

category deals with a special kind of thinking that we call *Disability as a deviation*. The children’s thinking in this theme mainly emanate from the questions: “What kind of disabilities do you know of?” (10), “When you meet somebody with [disability], what do you think of?” (11a) and “How can you recognise a child with [disability]?” (11b).

Naming a disability

Data belonging to this category reflects what the children seem to consider disabilities. The 16 children mention altogether 66 names of disabilities, between 1 and 9 names each and on average 4.2 names. The data can be divided into two groups: answers on the open-ended question “What disabilities do you know of?” (10) and answers where the interviewer asked leading questions in order to get information, like “Can a seeing difficulty be a disability?”

In Table 4 similar names are gathered in order to get a survey over the children’s names of disabilities. The names are divided into six kinds of disabilities: Physical and moving disabilities, Seeing disabilities, Hearing and speaking disabilities, “Mental” and “learning” disabilities, Agent Orange-related disabilities and Remaining names of disabilities.

Table 4

The 16 informants’ names of disabilities divided into six kinds of disabilities

Disabilities (66 names)	Open-ended questions (51)	Leading questions (15)
Physical and moving disabilities (24)	‘lost one leg’ (2), ‘losing leg’, ‘one leg’, ‘legs’, ‘losing arm’, ‘lose arm’, ‘arm’, ‘arms’, ‘one hand’, ‘paralysed’ (4), ‘born with heart disease’ (2)	‘moving difficulty’ (4), ‘difficult to walk’, ‘cannot walk’, ‘arm cannot move’, ‘cannot pick up anything’
Seeing disabilities (11)	‘blind’ (4), ‘something wrong with eyes’, ‘eyes’	‘blind’ (3), ‘seeing difficulty’ (2)
Hearing and speaking disabilities (9)	‘deaf’ (4), ‘impaired hearing’, ‘mute’ (4)	
“Mental” and “learning” disabilities (5)	‘slow in remembering things’, ‘cannot remember things’, ‘something wrong with the brain’	‘learning difficulty’ (2)
Agent Orange-related disabilities (5)	‘Agent Orange’ (3), ‘affected by Agent Orange’ (2)	
Remaining names of disabilities (12)	‘malnutrition’, ‘lack of calcium’, ‘nose bleeding’, ‘wounded’, ‘being bitten’, ‘small muscles’, ‘muscles are weak’, ‘handicapped’, ‘face’, ‘HIV’, ‘caffeine’, ‘malaria’	

Two of the five children who mention names related to Agent Orange seem to consider ‘Agent Orange’ as a disability in itself. The other four children seem to think, after further exploration, that ‘Agent Orange’ consists of different disabilities. For example, G6 gives the following description of someone who is affected by Agent Orange: “Compared to us, they are shorter, they cannot hear, they cannot see, and sometimes they are very thin.” In open-ended questions only three names deal with “Mental” and “learning” disabilities: ‘slow in remembering things’, ‘cannot remember things’ and ‘something wrong with the brain’. Seven of the 12 names grouped in Remaining names of disabilities were mentioned by two of the CwD, for example ‘nose bleeding’ and ‘malaria’.

Recognising children with disabilities

As Table 5 shows, the answers in this category can be divided into three types: recognising CwD by *Appearance*, recognising them by *Interaction* and *Not recognising* those children.

Table 5
Three types of answers about recognising children with disabilities

Type of answer	Children	Statements
Recognising by <i>Appearance</i>	8	13
Recognising by <i>Interaction</i>	5	13
<i>Not recognising</i>	6	6

The 13 disabilities about recognising by *Appearance* are: ‘malnutrition’, ‘lack of calcium’, ‘Agent Orange [disability]’ (3), ‘paralysed’ (2), ‘small muscles’, ‘blind’ (3), ‘lost one leg’ and ‘lost one arm’. G1 says that a boy or a girl with malnutrition “looks very small and very thin”. G14, B11 and B12 seem to think differently about how to recognise children who are blind. G14 recognises children who are blind because “they have to use a stick to help them walk.” B11 says that “blind children’s eyes are often white.” B12’s way of recognising children who are blind is also related to the eyes:

- B12: “They [‘blind’] have something around their eyes.”
- INT: “What do they have around their eyes?”
- B12: “Because they have some kind of cover for their eyes.” (Example 1)

The children who make statements about recognising CwD by *Interaction* mention Seeing disabilities, “Mental” and “learning” disabilities and Hearing or speaking disabilities. Four of the statements emanate from G10, who for example says: “If a mute student in the class, she or he cannot read the book when the teacher asks them to read.” All five children except G16 talk about one

disability at a time. G16 describes in a long sentence how she recognises four different disabilities that she connects with Agent Orange:

G16: “I think I can realise like that: if I talk to them and they can’t answer me it means that they are mute. And when they ask me ‘what are you saying?’ I know that they are deaf. And if I realise that they cannot see anything I know that they are blind. And if I ask the name of some child and they cannot remember, I know they have something wrong with the brain.” (Ex. 2)

G16 thinks, according to the quotation above, that she can recognise three of the mentioned disabilities by *Interaction* (‘mute’, ‘deaf’, and ‘something wrong with the brain’). She also says: “If I realise that they cannot see anything I know that they are blind”, but this does not necessary mean that she recognises children who are blind by *Interaction*. *Not recognising* disabilities is the last type of answer in this category. For example, some children mention ‘heart disease’ (2), ‘deaf’, ‘Agent Orange [disability]’, ‘blind’, ‘HIV’ and ‘paralysed’. One example is G14, who says: “I cannot know whether my friend has HIV.”

Thinking and feelings when meeting persons with disabilities

All of the 12 children (26 statements) in this category seem to perceive “somebody” in question 11a as a group of people with the same disability, which is shown in statements like “the deaf people” and “blind people”. This means that we cannot know whether they were thinking of children and/or adults with disabilities. However, none of the children mention CwD specifically. In spite of the question’s focus on thinking, the majority of the children answered what they feel when meeting somebody with a disability. Only five children answered (in eight statements) what they think of, whereas 11 children included descriptions of feelings (in 18 statements).

One example of the children’s thinking in this category is G6, who thinks that persons with Agent Orange disability “are human beings just like the others and they are victims of the war.” Also when meeting someone with a hearing impairment, she associates that disability with war:

G6: “They [‘deaf’] have sacrificed themselves for the nation and for the country during the war.” /.../

INT: “What kind of war?”

G6: “First it was the French war and second was the American war.” (Ex. 3)

In the group of answers about feelings common statements are “I feel sorry for them” or “I feel pity for them”, which occur in 12 of the 18 statements. One example is B11, who talks about persons who are blind:

B11: “I feel sorry for them [‘blind’].”

INT: “Why do you feel sorry for them?”

B11: “Because they are blind. They cannot see things.” (Ex. 4)

Four statements that originate from three girls are about feelings of love and/or sympathy, which no boy mentions. One example is G16, who says: “I always feel sympathy, love and want to help them [‘mute’]”.

Disability as a deviation

Statements in all the three themes show that some of the children seem to think of disabilities as “deviant” in one way or the other. In this category we have gathered statements about CwD where the deviation is more or less explicit. Four children have five statements that point to this way of thinking. One example is G6, who says that some children think that children with Agent Orange disability “are abnormal”. Another example is G7, who also talks about those who are affected by Agent Orange:

G7: “They [‘affected by Agent Orange’] were not born as an ordinary person.”
(Ex. 5)

The statement above indicates that G7 thinks that children ‘affected by Agent Orange’ were not born as “ordinary” children, i.e. that those children are “deviant”. G7 also says that children who are paralysed “cannot play like ordinary children”, i.e. she once again seems to think of children as either “ordinary” or “deviant”. One child, B4, says that children with moving disabilities “do not move normally”.

The nature of disabilities

This theme has two categories, which deal with the children’s thinking about the acquirement of disabilities and the possibilities for disabilities to change during a lifetime. The first category, *Causes of disabilities*, basically contains data from the questions: “What do you think causes [disability]?” (11c) and “Could you get [disability]? How/Why not?” (11d). The second category, *Disabilities’ development and duration*, mainly contains data from the question: “Will s/he have [disability] for the rest of her/his life?” (11f). This leading question gave rise to fewer and shorter answers.

Causes of disabilities

The statements gathered in this category can be divided into two types: Thinking about disabilities as *Congenital* and thinking about *Acquiring disabilities after birth*. As seen in Table 6 these two types are divided into five subgroups that are further elaborated below.

Table 6*Two main types and five subgroups of disabilities' causes*

Type of cause	Children	Statements
<i>Congenital</i>	7	10
<i>Agent Orange-related (congenital)</i>	3	3
<i>Acquiring disabilities after birth</i>	14	24
<i>Agent Orange-related (after birth)</i>	4	4
<i>Behaviour</i>	6	8
<i>Diseases</i>	4	4
<i>Accidents</i>	7	8

The disabilities mentioned as *Congenital* are: 'blind', 'wrong eyes', 'paralysed', 'small muscles' and 'heart disease'. One of the two children who associate heart disease with congenital causation is himself a CwD. He says: "I was born with heart disease." Some children mention that the disabilities 'slow in remembering things', 'deaf' and 'mute' are *Agent Orange-related (congenital)*. G7, who thinks that Agent Orange causes deafness and muteness, develops her thinking in Example 6:

G7: "I think that maybe if the father or the mother were involved in the battlefield, they were fighting in the battlefield, and then they were infected with something, and then when they give birth to the child, their child maybe is deaf or mute." (Ex. 6)

B3 says about 'slow in remembering things': "Maybe because their parents were involved in the war and they were affected by Agent Orange. They took that from their parents." Four children explain that "something was spread" and that the parents got "infected or affected with something". These statements are examples of *Agent Orange-related* causes occurring after birth. One of the children, B11, describes in Example 7 how the contact with Agent Orange can cause 'loss of one leg or one hand':

B11: "They lost their leg or hand when they were affected by Agent Orange.
/.../ When they were adults and they got outside they were affected by Agent Orange."

INT: "/.../ Could you get affected by Agent Orange?"

B11: "At present, no. /.../ Because there is not any war now." (Ex. 7)

Fourteen children mention the possibility of *Acquiring disabilities after birth*. Causes of this kind of disabilities can be divided into *Behaviour*, *Diseases* and *Accidents*. Eight statements by six children are connected to *Behaviour*. For example, some children say that a person who reads, plays computer games or studies too much can become blind or short-sighted. G10 says that persons who

are blind “learn too much and the electricity is not..., the light is not strong enough so they get blind.” Two other examples of *Behaviour* as causes of disabilities are when a person does not wash his or her ears or shout too much, which can cause deafness. G5 explains in Example 8 in a similar way how muteness arises:

- G5: “Because at home they [‘mute’] always speak so loudly and shout so loudly. /.../ Speak loudly and talkative.”
 INT: “How do you speak talkative?”
 G5: “Talkative, it means talk about anything and every issue, so we should not talk to, touch every issue, just say the thing we need to say.” (Ex. 8)

Four children mention that *Diseases*, for example infections and viruses, can cause disabilities. We interpret the following statement by B11 as if he thinks of blindness as transmittable (like a disease): “We can be blind if we use dirty water and share the towel with blind people.”

Almost half the sample mention *Accidents* as causes of moving disabilities, especially traffic- and war-related accidents. *Accidents* related to eyes and blindness are mentioned three times, for example by G14, who says that people get blind “because someone hit their eyes”. More than half the sample mention war-related causes of disabilities. Those statements appear in *Agent Orange-related* causes of disabilities (congenital and after birth) and *Accidents*.

Disabilities’ development and duration

As shown in Table 7 the children’s statements about disabilities’ development and duration can be divided into *Chronic*, *Finite* and *Compensating* for disabilities.

Table 7
Three types of answers about disabilities’ development and duration

Type of answer	Children	Statements
<i>Chronic</i> disabilities	4	13
<i>Finite</i> disabilities	4	4
<i>Compensating</i> for disabilities	4	4

B13 mentions an example of *Chronic* disabilities by saying that his uncle “has lost his leg for a lifetime”. Five of the eight disabilities mentioned as *Chronic* are different kinds of moving disabilities, for example ‘lost one leg’ and ‘leg is smaller’. The four children who mention *Finite* disabilities discuss the following disabilities: ‘slow in remembering things’, ‘being bitten’, ‘mute’ and ‘blind’. All four children have difficulties to describe how the cure will occur. B3 seems in Example 9 to have ideas about when, but not how, the change will occur:

INT: “Do you think that she [‘slow in remembering things’] will have this for the rest of her life?”

B3: “No.”

INT: “When do you think that she will come to remember?”

B3: “After we finish Grade 12.” (Ex. 9)

When asked about what will happen after Grade 12, B3 shows by shaking his head that he does not know. The third group in this category consists of four children, who mention *Compensating* for disabilities. Two of the mentioned compensation strategies are about using an artificial leg. For example, G5 says: “There is a stick linked to the broken leg and they walk like that.” G16 tells in Example 10 that her uncle seems to compensate for deafness:

G16: “I think that he [uncle] will not be deaf for his whole life, because a few days ago when I met him on the street I saw he had something in his ear. So when I said hello to him, he realised it and he understood.”

INT: “What did he have in the ear?”

G16: “Maybe it’s an invention to help the deaf, I don’t know exactly.” (Ex. 10)

The social treatment of children with disabilities

The three categories in this theme deal with the social treatment of CwD. The first category, *Children with disabilities’ access to play*, is about the children’s social treatment of CwD when they play together. The other two categories, *My treatment of children with disabilities* and *Others’ treatment of children with disabilities*, are not about a specific activity but deal with social treatment in different kinds of interactions with CwD. The children’s thinking in this theme mainly emanate from the questions: “When you meet somebody with [disability], what do you think of?” (11a) and “If a child has [disability], how do other children treat him or her?” (11e).

Children with disabilities’ access to play

This category consists of seven statements from five children. Five of these statements show that the children can think that CwD do not have the access to play. One example is B11, who in Example 11 talks about children who are blind:

B11: “If he [‘blind’] is in my class, other children will not play with that person.”

INT: “Why, do you think?”

B11: “Because they are blind and cannot see things so other pupils don’t want to play with them.” (Ex. 11)

B11 also says that “not many children would play with them [‘affected by Agent Orange’]”, because “they cannot play football for example”. G16 says that children do not play with a mute girl “because they cannot communicate or talk

to her.” According to G16 other children will tell a girl who plays with a mute person: “Oh, you are playing with a mute person!” One of the girls with disability in the class says that she only plays with her sister and the other girl with disability in the class. The reason for this is, according to herself, that most of the children in the class, especially the boys, hate her because she is “not clever and not a good student”. In Example 12 G16 says that she sometimes plays with the two girls with disabilities in the class, but that they do not like to play with her:

G16: “Sometimes I play with the weak friends, the weak persons, but they don’t like playing with me.”

INT: “Who are the weak persons?”

G16: “[The two girls with disabilities]”

INT: “Are there any other weak friends?”

G16: “[One of the boys with disability] is also a weak person but he never plays with girls.” (Ex. 12)

This example also shows that G16 seems to think that three children in her class are “weak”, i.e. three of the CwD in the class. The fourth CwD is aware of his disability and his limitations when playing: “It’s very painful if I run too much. /.../ If I stop for a while, I feel better.”

My treatment of children with disabilities

Even if we did not ask the children about their own treatment of CwD the data includes seven statements about this, mainly answers on “When you meet somebody with [disability], what do you think of?” (11a). Four girls and no boys mention their own treatment of CwD. The statements in this category can be compared with the examples of “*Well*” treatment in the category *Others’ treatment of children with disabilities* below, i.e. the statements are exclusively about helping and supporting CwD. G16 says in a quite general way that “I always help them [‘mute children’]”, but we do not know what kind of help she was thinking of. Four of the seven statements include concrete examples of how the children can help CwD. One example is G10, who says about deaf children that “I talk to them when no-one talks to them”. The same girl says about persons who are blind that “whenever they cross a street I always come and help them to cross the street.” Another concrete example comes from G14, who in Example 13 talks about children who have lost one arm:

G14: [about ‘lost one arm’] “I want to help.”

INT: “You want to help. And how do you help someone with only one arm?”

G14: “Just hold her arm.” (Ex. 13)

The following statement, also by G14, is the only example of when the child wants to help CwD but does not seem to know how: “I hope that I can help them [‘HIV’], but I don’t know how to help them.” The last example of the children’s own treatment of CwD is G16, who says that she sometimes plays “with the

weak friends, the weak persons, but they don't like playing with me.” That quotation is the only example of someone who wants to be kind and supportive, but the CwD do not want her help (according to G16).

Others’ treatment of children with disabilities

The main source of information for this category is answers on “If a child has [disability], how do other children treat him or her?” (11e). Table 8 shows that the category contains four types of treatment: “Well” treatment, “Badly” treatment, *Combined descriptions* (“Well” and “Badly” treatment) and “Normally” treatment.

Table 8
Four types of treatment of children with disabilities

Type of treatment	Children	Statements
“Well” treatment	7	10
“Badly” treatment	6	8
<i>Combined descriptions</i>	6	7
“Normally” treatment	3	5

Seven children, five of them boys, talk about “Well” treatment. Three statements from two boys are short and general, i.e. they say that other children treat CwD “well” or “very well”. Five statements are related to studies and two of them come from B3, who in Example 14 expresses his thinking about children who are ‘slow in remembering things’:

B3: “They [other children] take good care of children who are slow in remembering things and they try to help them in studying.” (Ex. 14)

B3 does not say anything more about how children help children who are ‘slow in remembering things’ in their studies. A more concrete example comes from B15, who says that other children “will bring that paralysed child to class, to the classroom.” G14 says in a similar way: “If I’m blind and want to go home, some other friends would help me to go home”. This example is very similar to how B13 seems to think about how other children treat someone who has lost one leg. He says that children will tell the child with one leg: “If you are tired I can take you home”.

To continue with examples of “Badly” treatment, six children (four of them girls) express their thinking about this issue. B4 says that other children “make fun of him [‘one arm’]”. G7 talks similarly in the following sentence about children who are ‘affected by Agent Orange’: “when they go to school some others make fun of them, and then, they don’t understand about the disabilities

so they make fun of them.” Example 15 shows that G10 might think that other children treat children who are deaf “*Badly*”:

G10: “They [other children] do not behave very well.”

INT: “How do they behave?”

G10: “They always make fun of them, and even beat them sometimes.”

INT: “And what do they say to them?”

G10: “They always gossip about the deaf person’s parents, and also blame their parents.”

INT: “Why do they blame them?”

G10: “Because the parents do not take care of the disabled people very well.”

(Ex. 15)

The same girl, G10, says about blind children that other children “always make fun of them, or beat them”, and that the other children “always shout out: ‘Hey, this is a blind girl!’”

Three statements deal with other children’s “*Badly*” treatment of the two girls with disabilities in the class. G7 says that “other friends of mine often tease them”. This is confirmed in statements by the two girls with disabilities who themselves say that they have experienced “*Badly*” treatment. One of those girls says that one of the boys with disability “often beat me”. The other girl says: “The boys hate me and beat me /.../ and they look down on me”. Some statements from this girl with disability show that she has also experienced what we call “*Well*” treatment, which means that her statements altogether can be classified as *Combined descriptions* (“*Well*” and “*Badly*” treatment). She repeats that the boys beat her, but a little later adds that the other girl with disability “is a nice friend”; “She always helps me to study by asking me to come to her house to study.” There are also other children who treat her well: “When I was beaten the friends from [another class] they tried to prevent the others from beating me.”

An example of *Combined descriptions* that does not discuss the CwD in the class comes from G7, who in Example 16 talks about children who are paralysed:

G7: “I think that some of them [other children] will help the paralysed children with their studies while others may tease them.”

INT: “What do they say to them?”

G7: “They tease them for a while, then they start helping them.”

INT: “Why do they start helping them?”

G7: “Because the monitor or the head of each group can ask the friends to be nice to that person.” (Ex. 16)

Yet another example of *Combined descriptions* can be G6, who says that there are “two kinds of attitudes” toward children with ‘Agent Orange [disabilities]’: “Some people treat them normally and feel sympathy for them but the others

have a bad negative attitude toward them. /.../ They always make fun of that person.”

The last type of answer in the category *Others' treatment of children with disabilities* is examples of “Normally” treatment, which three children mention. When asked about how other children treat children with ‘malnutrition’, ‘lack of calcium’, ‘heart disease’ (2) and children who are ‘blind’, the interviewees simply answers “Normally” or “Very normally”.

Discussion

The aim of the present study was to investigate what children in a Vietnamese primary Inclusive Education class think about disabilities. Before we discuss the results we would like to evaluate the method used.

Method discussion

The explorative approach of the study seemed to be advantageous in many ways. By using semi-structured interviews (Doverborg & Pramling Samuelsson, 2003; Lantz, 1993; Silverman, 2002) we could go deeper into specific answers when needed. At the same time, when using semi-structured interviews there can be a risk of the interviewer influencing the child to produce confirmed answers (Hill & Rabe, 1994). However, the result as a whole shows varying descriptions of the children’s thinking about disabilities, i.e. the semi-structured interview seems to have served its purpose (Doverborg & Pramling Samuelsson, 2003). Also, our use of open-ended questions (Cederborg, 2000) might have contributed to the various descriptions. One example is the question “When you meet somebody with [disability], what do you think of?” (10). This question gave rise to answers that seem to indicate both what the children think and feel when meeting somebody with a disability. Leading questions seemed to produce more limited information. In question 11a we of ethical reasons chose to ask about the children’s thinking when meeting “somebody” with a disability. A risk with this approach, i.e. asking about “somebody” instead of “CwD”, is that we might not know whether the child talked about children or adults.

Researchers (Lundh et al., 1992; Wood, 1999) state that by interviewing children one can get a picture of their thinking about an issue, but also that there can be a discrepancy between what one thinks and what one says (Alerby, 1998). In the present study this issue has been even more critical because of the use of interpreters (Wadensjö, 1998). In order to get reliable data we asked the

interpreters to translate one or maximum a few statements at a time. To get as good contact as possible we looked at and talked directly to the children and in most cases they talked directly to us. We noticed this by the children's use of the male vocative form "Anh", i.e. "older brother" (Pham, 1999, p. 22; Rydstrøm, 2003, p. 191). This might indicate that they were talking to us and not to the female interpreters. Also, we believe that our presence during the breaks might have made us more "familiar faces" (Beresford, 1997), which can also have contributed to a more comfortable interview situation for the children (Doverborg & Pramling Samuelsson, 2003). Still, there is always a risk that the informants might think that a question meant something other than intended, especially since the interviewers and the children were of different ages, did not know each other from before and had different cultural backgrounds (Beresford, 1997; Ryen, 2001).

Result discussion

Although the children represent 16 different perspectives many of them brought up the same issues, which we have divided into the themes *Meeting disabilities*, *The nature of disabilities* and *The social treatment of children with disabilities*. In general, there seem to be many similarities between the children's thinking about disabilities, but also differences. To begin with, 54 of the 66 names of disabilities mentioned seem to correspond with the Parliament of Vietnam's (1998, in Huff et al., 2003) definition of disability (see *Disability defined*). Seven of the 12 remaining names, like 'nose bleeding' and 'malaria', were mentioned by two of the CwD. This can indicate that those children might think of names of disabilities slightly differently from their non-disabled peers. Research (Huff et al., 2003) shows that physical and moving disabilities are the most common disabilities in Vietnam. This was also the case in the present study, in which a third of the children mentioned those kinds of disabilities. According to the University of Pedagogy in Hanoi (1998, in Lindskog & Nguyen, 2002) almost one-third of Vietnamese children's disabilities are learning disabilities. Also, children's thinking about disabilities can be influenced by the frequency with which they interact with CwD (Diamond & Innes, 2001; Hill & Rabe, 1994; Nordström, 2002; SOU, 1998; Tamm, 2001). We were told that three of the class' children had "mental" or "learning" disabilities, but the children in the class had not received that information (headmaster of the school, personal communication, 17th September, 2003). In our study the children only mentioned "mental" or "learning" disabilities on five occasions (out of 66).

Especially younger children often seem to be dependent on concrete features to be able to perceive disabilities (Diamond et al., 1997, in Diamond & Innes,

2001). This can be compared with 13 statements in this study where children claim to recognise disabilities by *Appearance*. One example is G14, who says that she recognises children who are blind because “they have to use a stick to help them walk”. However, five children also mentioned that they recognise CwD by *Interaction*, which might not have been the case if we had interviewed younger children with less developed thinking (Lawenius, 1998). G16 (Ex. 2) describes for example in a long sentence how she recognises four different disabilities (three of them by *Interaction*).

Many disabilities in Vietnam are war-related (Bierman, 1997; Lindskog & Nguyen, 2002; UNICEF, 1990), which is also mentioned by more than half of the sample in this study. War-related statements are also found in the categories *Recognising children with disabilities* (Ex. 2), *Thinking and feeling when meeting persons with disabilities* (Ex. 3) and *Disability as a deviation* (Ex. 5). This can be discussed in the light of the many war-victims in Vietnam (Bierman, 1997), for example the 36 children in an institution near *The Tieu Hoc School* who were described as “victims of war” (headmaster of the school, personal communication, 17th September, 2003). One documented (Huff et al., 2003; Lindskog & Nguyen, 2002; UNICEF, 1990) war-related cause of disabilities in Vietnam is the herbicide Agent Orange, which some children mentioned. These children said that Agent Orange can lead to for example: ‘slow in remembering things’, ‘deaf’, ‘mute’ and ‘loss of one leg or one hand’. Research (Bich et al., 1994; Fukuhara et al., 1994; Schytt, 2003-11-03; UNICEF, 1990) shows that Agent Orange can cause malformations, neurological impairments and paralysis. When comparing this with the children’s statements it seems like ‘loss of one leg or one hand’ are more plausible effects of Agent Orange than for example ‘deaf’ and ‘mute’. Four informants seem to have quite vague ideas about how Agent Orange can cause disabilities. Research (in Schytt, 2003-11-03) shows that Agent Orange is absorbed from food and transmitted from mother to baby through breast milk. In the present study, B3 simply says that children ‘slow in remembering things’ “took that from their parents”.

Compared with Agent Orange many children seem to find it easier to define the connection between *Accidents* and disabilities, which almost half of the sample mentioned. In Vietnam there is a strong tradition of teaching children acceptable behaviour (Lindskog & Nguyen, 2002; Ngô, 2000; Rydstrøm, 2003). Six children mentioned *Behaviour* as causes of disabilities, for example G5 who says that talking too much can lead to muteness. Also, disabilities in Vietnam have been considered as a result of a person’s bad deeds in previous lives (Bierman, 1997). This was however not something that we found in this study. On the other hand recent research (Huff et al., 2003) shows that most people in Vietnam nowadays do not share that kind of traditional belief.

When asked about what the children think of when meeting somebody with a disability, 11 of them also included descriptions about feelings. Twelve of the 18 statements about feelings show that the children might “feel sorry for” persons with disabilities or “feel pity for them”. This result seems similar to both international research (Lawenius, 1998; SOU, 1998; Tamm, 2001) and Vietnamese research (Bierman, 1997; Huff et al., 2003) showing that children can think of persons with disabilities as inferior and unhappy. Research (Huff et al., 2003; Lawenius, 1998; Tamm, 2001) also shows that children often think that those persons should receive help and sympathy. Three girls and no boys in this study mentioned that they feel love and sympathy when meeting persons with disabilities, and that they want to help them. One example is G16, who says: “I always feel sympathy, love and want to help them [‘mute’]”. This might also be understood with respect to the Vietnamese term “tinh cam”, i.e. “feeling of solidarity, sympathy” (Kleinen, 1999, p. 209). According to “tinh cam” girls should be sensitive about when to assist a person who needs help (Rydstrøm, 2003). In our study four girls (and no boys) in the category *My treatment of children with disabilities* say that they try to support and help CwD. One of the statements about thinking when meeting a person with disability comes from G6, who mentions that persons who are deaf “have sacrificed themselves for the nation and for the country during the war” (Ex. 3).

Two boys mention in a quite general way that other children treat CwD “well” or “very well”. Some children also have more detailed statements about the issue, indicating that they for example might think that other children help children who are ‘slow in remembering’ (B3 in Ex. 14). Other examples of “Well” treatment are G14 and B14 who say that other children will help CwD to and from school, which also Ta (in Alfredsson, 2001) describes. G7 says that children help children who are paralysed “because the monitor or the head of each group can ask the friends to be nice to that person” (Ex. 16). This might be compared with when classmates in a so-called Circle of Friends support the CwD (Lopez & Ta, 2000). According to Huff et al. (2003) and Le (1999) Vietnamese children can both help and respect CwD, but also tease them. Statements in this study’s category *Others’ treatment of children with disabilities* show that children both seem to think that other children take “good” care of CwD and also that they might think that children treat those children “Badly”, for example by teasing and beating them.

Research shows that children who are blind often are isolated (Persson & Sköld, 1995, in SOU, 1998). G10 says that children “make fun of” children who are blind, sometimes beat those children and might yell: “Hey, this is a blind girl”. Tamm (2001) states that CwD in Inclusive Education classes are often teased both physically and verbally in statements relating to the disability. Both the girls with disabilities in the sample seem to have experienced “Badly” treatment,

mainly from boys. We can also notice that the results do not indicate that the two boys with disabilities in the class were teased or subject to “*Badly*” treatment in other ways.

Five statements in the category *Children with disabilities’ access to play* show that some of the children seem to think that other children do not want to play with CwD, which other research also shows (Huff et al., 2003; Ta, 2000; Tamm, 2001). For example, B11 says that “other pupils don’t want to play with them [blind children]” (Ex. 11). One of the girls with disabilities says that she only has two friends because she is “not clever and not a good student”. This statement indicates that she might think that other children do not want to play with her because of her “mental” or “learning” difficulties. According to Diamond (1993, in Diamond & Innes, 2001) children often perceive children with mental disabilities as less competent also in physical activities. We were told that the girl mentioned had a “mental” or “learning” disability, which might not be equivalent to “mental disability” in Diamond’s study. Still, it seems that the girl with disability herself thinks that her disability also affects her access to play. G16 (Ex. 12) seems to categorise three of the CwD in the class as “weak”, but does not mention the boy with heart disease who is the only child with a physical disability. This too might be compared with Diamond’s research, which shows that children often seem to perceive children with physical disabilities as less competent only in physical activities.

Since we used interpreters we cannot know the exact word G16 above used, i.e. if she used the word “weak” or not. Still, the translation of her statement indicates that she might think of CwD as “deviant” in one way or the other. Another girl, G7, mentions that children who are paralysed “cannot play like ordinary children” indicating that she too might think of children as “ordinary” or “deviant”. In the category *Disability as a deviation* four children seem to think of CwD as “deviant”, which other research has also shown (Le, 1999; Ta, 2000). However, the present study’s results on children’s treatment of CwD show that three of the children might also think that those children are treated “*Normally*”. Ta (in Alfredsson, 2001) states that peers sometimes perceive a CwD as an “ordinary” child, and Huff et al. (2003) state that children can think that those children should be treated like everybody else.

Finally, this study has raised some ideas for further research. One result of the study is the low frequency of mentioned “mental” or “learning” disabilities in spite of the fact that three of the four CwD in the sample seemed to have those kinds of disabilities. It would be interesting to study an Inclusive Education class where the children had received more information about the CwD and further discuss how such information might influence the children’s thinking about disabilities. Another research idea could be to investigate how the type of

disability might influence the children's thinking. What do, for example, children think about disabilities in a class where the CwD has Down's syndrome or CP? Since there is a lack of research on children's thinking about disabilities in Vietnam (Huff et al., 2003) it would also be interesting to examine how the children's thinking about disabilities is influenced by for example the teachers' and parents' ways of thinking. Furthermore, it would be interesting to investigate what Vietnamese children, who have not been in contact with CwD, think about disabilities. This has been investigated in other countries, for example Sweden and USA, but as far as we know only to a limited extent in Vietnam (Carlson, Helmstetter & Peck, 1992, in Diamond & Hestenes, 1996; Tamm, 2001).

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Appendix 1

Interview guide

As we told you the first day we met participation is voluntary and you can at any time change your mind regarding your participation. If you choose not to participate it will have no negative effects for you. Everything that you say will be treated confidentially and not even your teacher will know what we have talked about. Do you have any questions about this?

I come from Sweden and I am very curious what it's like to go to school in Vietnam. We will talk about this for a while and thereafter I would also like to hear what you think about some other issues. We will talk for about half an hour. If there is anything that you don't understand, please ask.

1. *Tell me what you usually do during the breaks at school.*
2. *Who do you play with?*
3. *Do you play with anyone else?*
- } Ask 1-3 if the child was not observed during the break

Warm-up-questions

4. Tell me what you did at the break today.
5. Who else participated?
6. What is it like to play with them?
7. Who is your best friend at school?
8. Do you have other friends at school? Who?
9. Do you sometimes play with boys/girls, too? What do you play?
-

10. What disabilities do you know of? Do you know of any other disabilities? *Can a seeing difficulty be a disability? Moving difficulty? Learning difficulty?*

11. a. When you meet somebody with [disability 1, 2, 3...], what do you think of?
Do you think of anything else?
b. How can you recognise a child with [dis. 1, ...]?
c. What do you think causes [dis. 1, ...]?
d. Could you get [dis. 1,...]? How/Why not?
e. If a child has [dis. 1, ...], how do other children treat him or her?
f. Do you know of any persons with [dis.1...]? Who?
g. When did s/he get [dis. 1, ...]?
h. Will s/he have [dis. 1, ...] for the rest of her/his life?

12. Do you know of any other disabilities? What disabilities?

Thinking about disabilities

Appendix 2

Letter to parents in primary class XX, in XX School

We are two Psychology students from Sweden doing a field study in Hanoi September-October 2003. The field study is a part of a final examination paper in order to gain a Psychologist degree. The study has been financially supported by the Swedish International Development Co-operation Agency (SIDA). In Hanoi, Ta Thuy Hanh, *Programme Officer/ Inclusive education* at Save the Children Sweden, is the contact person. Tutors in Sweden are Ann-Christin Cederborg, *Ph.D. Associate Professor*, and Helle Rydstrøm, *Ph.D. Assistant Professor*, at the University of Linköping.

This study is concerned with the educational project Inclusive Education (IE). The IE concept is based on the idea that all children have the right to develop their personality and capacities. The aim of the field study is to investigate school children's experiences of studying in an IE class.

Students in primary class XX, in XX School, are hereby asked to participate in the field study. A part of the study is to observe and interview 12-16 school children. The interviews will be interpreted from Vietnamese to English and will take approximately one hour. We will visit the school a few hours daily during two weeks, starting from the 16th September.

The interviews will be recorded and the recorded material will be deleted immediately after the study. All the collected information will be treated confidentially, i.e. the children's real names will not be used in order to make it impossible for others to identify any child. You may, at any time, change your mind regarding your child's participation in the field study, since participation is voluntary. No one beside us will have access to the research material, which will only be used for the purpose of research. The final report will be available through Save the Children Sweden in Hanoi. If you have any questions, please contact us or our contact person.

Yours Sincerely,

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I hereby give permission for my child to be observed and interviewed, and I ensure that my child has received the information in this letter.

Date: _____

Parent's signature: _____

My child's name: _____