

*The Impact of Cultural Development of Disabled Identity on Special Education Systems  
in the US and Japan: A Comparative Analysis*

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**Abstract**

This paper presents a comparative case study of the history of special education in the United States and Japan along with an overview of contemporary public education in each nation. Are the same populations considered disabled in each system? Which, if any, disabled people receive special education services? American culture veers sharply towards individualism and in the classroom emphasis is often placed on preparing for standardized assessments of academic achievement. In contrast, Japanese public education focuses initially on developing the classroom as a unit and creating a strong community in which children are not othered for their differences, positive or negative, before the more competitive academic years begin. Particular attention is paid to the Japanese phenomenon of hikikomori, teenagers and young adults who have undergone voluntary withdrawal from society, as well as the increased diagnosis rate of ADHD in the US, two circumstances that appear to be highly culturally specific.

Keywords: Special Education, Disability, Hikikomori, ADHD, Social Model

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## Introduction

Disability is influenced and defined by social factors as much as by physiological ones— a person who is disabled in one context may be abled in another. To draw on personal experience, I am not disabled on the Internet. I am able to type quickly, navigate web pages, read text, and engage with visual media without accommodations such as screen readers or dictation software. In the physical world, I am disabled. I use a cane to walk, medication to manage symptoms, and have to carefully plan my daily routines to assess what accommodations I will need. My level of ability is heavily contextual and often determined by things having nothing to do with my body and individual capabilities. A dyslexic child may be disabled in an American classroom, which relies heavily on reading and writing as a mode of communication, but abled in social contexts where they are able to communicate verbally and visually. This is the social model of disability, which relies on context and interpersonal factors much more than the medical model's analysis of a person's diseases or disorders.

As the field of disability studies increasingly shifts to the social model over the medical model, there is an opportunity to reanalyze existing systems such as that of special education. The fact that different populations are eligible for special education in different countries is a strong point in favor of the social model because it allows for a culturally contextual history and analysis of such education systems. In many Western countries, the first instances of special education initiatives were founded by religious institutions: schools for the blind and deaf, institutions for intellectually disabled people, and other organizations maintained as charitable endeavors by different denominations. This early association between charity and disabled people is still a persistent factor in the stigmatization of disability, particularly as it relates to social services, including public school accommodations.

Because of my personal background as both a student and educator in American public schools, I chose the US for further exploration in this case study. I attended public school in the Dallas, Texas area from kindergarten until I graduated high school and received services through the gifted and talented program, which was administered separately from special education services. As a graduate student, I work part-time as a classroom aide in an integrated special education/mainstream preschool run through a local public school district. Through this work, I have learned much about the process through which students, some as young as two years old, are assessed and entered into the special education program to receive services such as occupational, physical, and speech therapy as well as classroom support.

After examining the accessible literature on international special education, it seemed that discussion of Japanese education systems would provide the deepest well to draw upon for comparison. The work of Kayama and Haight in particular provided valuable examination of Japanese school culture and the recent restructuring of the Japanese special education system as well as historical context on the development of special education in Japan. Additionally, the research of Kato and Teo into the *hikikomori* phenomenon has given insight into a uniquely acculturated facet of disability.

A note on language: I have made an effort throughout this paper to use language that is accessible to those who are not in academia by limiting jargon and explaining terms that might otherwise be undefined. This is a part of my personal pedagogy of demystifying academic literature in light of the limited access many people have to higher education.

## The Arc of American Special Education

### How American Public Education Works

In the United States, public education systems are managed at the state level and overseen federally. While exact requirements vary from state to state, students are generally required to attend school through age sixteen or until they obtain a high school diploma or equivalent (National Center for Education Statistics [NCES], 2017). Primary school typically focuses on literacy, arithmetic, and civics education, and forty-six states use standardized tests to assess student capabilities in these areas before students reach third grade (NCES, 2018). Elementary students are generally instructed in reading, writing, mathematics, science, social studies, music, art, and physical education, although the emphasis and time devoted to the latter four subjects varies widely from state to state. Increasingly, states are implementing a STEM or STEAM curriculum (science, technology, engineering, (art), and math) from an elementary level onwards. When students reach junior high or middle school, instruction in history, foreign languages, drama, and more specialized electives may be added to the curriculum. Historically, high schools offered vocational training in the form of home economics, automobile or wood shop, and cosmetology classes, along with work-study and work-release programs (Dreilinger, 2021). After a sharp decline in such classes associated with the rise in college-readiness as a focus of high school, many states are once again instituting vocational training as one curriculum track for students in their last years of compulsory education (Cantor, 1989; Lewis, 2007).

While compulsory education was implemented in some form as early as 1642, and all states had a law on compulsory education by 1918, there was no federal legal mandate on special education until the passage of the Individuals with Disabilities Education Act (IDEA) in 1975 (Katz, 1976; Kauffman et. al, 2014). This is not to say that all disabled children were excluded from the classroom- schools for the education of blind students and deaf students were established by social reformers during the 19th century, and some of the most famous disabled Americans were educated there (Winzer, 2009). Deaf-blind student Laura Bridgman was taught at the Perkins Institute for the Blind beginning in 1837 and was widely touted as the first deaf-blind person to be taught language (Freeburg, 2001). However, these schools did not have the capacity to educate every deaf or blind student in the US, and students with other disabilities were routinely institutionalized in asylums or hospitals and denied access to education in any form (Winzer, 2009). There are anecdotal cases of students with cognitive or physical disabilities being accommodated in their neighborhood schools, at least in terms of being allowed physical access, but this physical access rarely correlated to appropriate education that accommodated the specific needs of the student (Kauffman et. al, 2014).

The 1954 Supreme Court decision in the case of *Brown v. Board of Education*, which ruled that the ‘separate but equal’ doctrine decided in *Plessy v. Ferguson* was unconstitutional and mandated the end of school segregation based on race, allowed for disability activists to challenge the exclusion of disabled students from public schools by extending the Due Process Clause of the Fourteenth Amendment to encompass discrimination based on ability. Two specific cases, *P.A.R.C. v. Commonwealth of Pennsylvania* and *Mills v. Board of Education*, established that public schools had to make every effort to accommodate disabled students in their local schools and that “Placement in a regular school is preferable to placement in a special school class is preferable to placement in any other type of program of education and training” (*P.A.R.C. v. Commonwealth of Pennsylvania*, 1971). These precedents and those from subsequent court cases became codified in IDEA the first federal

legislation concerning the right to free, appropriate public education regardless of disability status, as well as the right of the student to be educated in the least restrictive environment (LRE) and to receive an IEP, or individualized education plan (Kauffman et. al, 2014). IDEA underwent revisions in 1990 and 2004 and remains the primary legislation on the topic of special education.

### ***Special Education In Practice***

In the 2019-2020 school year, 14% of public school students aged 3-21 received some form of special education services, with the largest percentage (33%) of those students receiving services for a specific learning disability (NCES, 2021). Students can be referred for evaluation for special education services at any point in their education, and there are systematic screenings in place to identify disabled students whose needs are not being accommodated (Kauffman et. al, 2014). Once they are approved for special education services, their guardians and school district personnel have regular meetings to set an IEP and assess how well it is accommodating the student's needs as they move through the education system. Generally, special education students are mainstreamed, or included in general education systems, as much as possible. As part of their IEPs, they may have an aide who works with them one on one, or they may be part of a program in which special education teachers and general education teachers run a classroom together (Kauffman et. al, 2014). Most public schools also have one or more classrooms designated specifically for special education; students may spend their entire school day there, or use the room as a space for therapies, studying, or specific classes. These rooms are typically staffed by a full-time teacher and a number of aides, paraprofessionals, and part-time staff (Kayama & Haight, 2014).

Disability in the American school system is highly formalized and medicalized; in order to qualify for services, a student must be evaluated and diagnosed and the impact of their disability on different aspects of academic and social performance must be put in writing. This emphasis on the medical model has been heavily criticized by disability scholars (Abberley, 1987; Bickenbach et. al, 1999; Winzer, 2009; Kauffman et. al, 2014). Pathologizing disability does a disservice to students who are disabled but lack the resources or the knowledge to seek a formal diagnosis, or to those students whose disabilities are sufficiently rare enough as to be mysterious to medical professionals. Additionally, the emphasis American culture places on individual exceptionalism and academic achievement may cause disabled students who struggle academically to feel frustrated, depressed, or have low self-esteem (Silverstone & Salsali, 2003; Trani et. al, 2020). As with many aspects of American society, the special education system is affected by the legacy of racist laws and policies as well as pseudo-scientific ideas of how race impacts intelligence and academic ability. Students of color, particularly Black students, are statistically more likely to be diagnosed with a disability and placed in special education than their white peers (Skiba et. al, 2008; Fish, 2019).

One positive effect of the American approach to special education is the relative ease in attaining accommodations. Particularly with higher-incidence disabilities, there is already a system in place that recognizes the disability and has evidence-based education practices. For example, students with learning disabilities such as dyslexia have access to several decades' worth of research into how learning disabilities impact brain function, alternative methods of teaching literacy, and a higher rate of teacher understanding of their disability (Winzer, 2009; Kauffman et. al, 2014). This can allow students who might struggle in another national

education system to access accommodations that allow them to thrive academically and socially.

### **ADHD Diagnosis Rates: Creating An Adderall Nation**

ADHD, or attention deficit hyperactivity disorder, has catapulted to the national and international spotlight since the turn of the twenty-first century. While some aspects, particularly hyperactivity, have been described in medical literature for centuries, the modern diagnostic definition is a relatively recent evolution (Winzer, 2009). Rather than a constellation of behaviors, ADHD is now understood as a neurological processing disability that causes these behaviors and can be remediated with psychiatric medication. Matthew Smith (2017) argues that the international proliferation of ADHD is less an indicator that ADHD is a universal disorder and more a product of American psychiatric colonization and the aggressive marketing of stimulants by large pharmaceutical corporations by correlating countries with high incidence of ADHD to countries where companies such as Eli Lilly and Johnson & Johnson have a strong presence. To look at the numbers, ADHD emerged first in the United States and is now diagnosed in as many as 15% of all American children (Schwarz, 2016). The US accounted for 93% of all spending on ADHD medication in 2000 and 88% in 2010, indicating that other countries may be beginning to take a more American approach to ADHD treatment, i.e. the prescription of stimulants (Hinshaw & Sheffler, 2014).

In addition to potential colonialist implications of the proliferation of ADHD as a diagnosis, there is concern that the diagnosis is being used to label children when not clinically indicated as a way to explain ‘difficult’ behavior (Lange et. al, 2010). This has a racial component- students of color are far more likely to have their disruptive behaviors attributed to ADHD or other behavioral disabilities than their white counterparts- as well as a regional one- students in the American South are much more likely to be diagnosed with ADHD than those in other regions (Centers for Disease Control [CDC], 2020). Boys are as much as three times more likely to be diagnosed than girls, although this gender gap has been closing in more recent studies (Smith, 2017). Untangling the cultural influences in different diagnosis rates across specific demographics from the possibility of real physiological traits that impact incidence rate is a puzzle that may never be solved. It is impossible to define ADHD behaviors such as hyperactivity without assigning a cultural definition of normal behavior that is intrinsically and inescapably tied to national and historical constructions of social norms.

Another way of understanding the “ADHD epidemic” comes to us from disability scholarship: the increased rate of diagnosis is a result of increased understanding of the possible clinical presentations of ADHD as well as increased awareness by medical and educational professionals. For example, boys were historically diagnosed at much higher rates than girls, which is now understood as a difference in presentation, not in diagnosis. Boys are more likely to have hyperactive-type behaviors that are disruptive in classroom settings while girls are more likely to have inattentive-type behaviors that did not necessarily draw the attention of adults (Smith, 2017). This focus on classroom behaviors as a signal for assessment may go a long way towards explaining an American or Western bias in diagnosis- the American educational emphasis on standardized testing and individual academic achievement creates an environment in which teachers are encouraged to “control” disruptive behaviors, whether with medication, removing the student from a general education classroom, or other punitive measures. As discussed below, this is not a universal attitude,

but a cultural one. Students are expected to be individuals without straying too far from the behavioral norm; deviation is cause for assessment and possible medical intervention.

## **The Arc of Japanese Special Education**

### **How Japanese Public Education Works**

In Japan, students are required to attend school through eighth grade; high school is not required. Japanese primary school, which consists of grades one through six, focuses much more on social-emotional learning than the equivalent American grades (Kayama & Haight, 2014). Students are instructed in Japanese language, social studies, arithmetic, life studies, music, arts and crafts, science, home economics, and physical education. When they reach secondary school, art, technical arts, and foreign languages may be added to the curriculum, along with integrated studies and special activities. Moral education is interwoven into other subjects and students may occasionally have specific lessons only on morality (“National Curriculum Standards” 2017-2018).

Historically, students with disabilities have been excluded from Japanese classrooms to varying degrees, often depending on the type and degree of their disability. While compulsory elementary education was enacted in 1886, with an amendment providing for segregated schools for blind and deaf students in 1890, students with physical, cognitive, and behavioral disabilities were often given legal exemptions to these compulsory years due to lack of resources and understanding to set up classrooms for them and thus were left out entirely. After World War Two, the Japanese education system (which had been languishing in a state of some neglect due to the economic crisis of the Great Depression and the subsequent militarization of all aspects of Japanese society) was completely overhauled and provisions were made for educating disabled children in special education classrooms. The number of special education classrooms in mainstream schools began to steadily increase in the post-war years as the Ministry of Education began to offer specific guidance and as societal awareness and acceptance of disabilities increased (Kayama & Haight, 2014).

Schools for blind students and schools for deaf students are somewhat of an outlier to the overall special education system: the first such schools were set up before the implementation of compulsory education and benefitted from robust advocacy groups made up of both parents and blind or deaf people. While people with other disabilities, particularly cognitive disabilities, have been considered uneducable or ‘non-people’ at various points in Japanese history, blind people and deaf people were recognized as educable populations very early on (Kayama & Haight, 2014). This may be due in part to the existence of such cultural figures as the *biwa hoshi* and *goze*, two types of blind itinerant musicians, and the corresponding associations between blindness and ability (de Ferranti, 2009).

While American children are typically educated in their local schools as much as possible, regardless of the severity of their disability, Japanese children with severe disabilities may be enrolled in a school only for disabled children that has a separate curriculum and more staff who are specifically trained to work with disabled children (“Special Needs Education” 2021). Children with less severe disabilities, including many on the autism spectrum or with ADHD, are mainstreamed in general education classrooms as much as possible. General education schools may have a special education classroom, but it is more typically used for only part of a child’s day or as a place for them to seek respite when overwhelmed or frustrated (Kayama & Haight, 2014). Children may be referred for special education services

at any time, but with milder disabilities, there is a cultural practice of accommodating students in an informal way in general education settings (Borovoy, 2008).

### ***Accommodation In Deed, Not In Writing***

As in many cultures, disability is a historically stigmatized category in Japan. While acceptance and awareness are rapidly increasing, there is still a sense of shame and a loss of face associated with having a disabled child, particularly one who is enrolled in special education services. Thus, teachers may work to accommodate students' needs in an informal way. In one example, a student on the autism spectrum was accompanied by his mother on school trips at the request of the staff, even though he had no formal IEP (Borovoy, 2008, p. 567). Teachers may also work with students one-on-one outside of formal school hours or alter assignments to be accessible to the student. While this allows for increased mainstreaming of students, it may also increase feelings of frustration or helplessness for students who are later formally diagnosed with a disability (Leedham et al. 2019).

This frustration can lead to social isolation, a major cause of concern for Japanese teachers. Teachers are often more concerned by isolation and refusal to engage in group activities than by hyperactivity or disruptive social behaviors (Borovoy, 2008). Disruptive behaviors are not punished, but used as a learning opportunity for the entire classroom community. This can be attributed in part to the idea that "The self is understood as primarily relational and contextual." (Kayama & Haight, 2014, p. 12). Rather than a student's disruptive behavior being a reflection on their independent self, it is a reflection on the peer group as a whole. Students are encouraged to help one another regulate behavior and conform to age-appropriate standards of etiquette and interpersonal relationships. This inclusive classroom model has its pros and cons; as Borovoy (2008) states:

"The emphasis on equality can be seen as very much a double-edged sword. On the one hand, historically it has sustained an ideology of inclusion. The strong belief that Down syndrome children should be accepted in the "normal" classroom was associated with the idealistic belief that inclusion would allow stronger children to overcome their discrimination, and allow disabled children to benefit from mingling with mainstream peers. At the same time, inclusion is undeniably linked to an ideology of "sameness"—and the pressure to hide problems and assimilate into mainstream values." (p. 560)

Peer groups cannot be the sole source of support for a disabled student. The impetus is often placed on caregivers, be they teachers, parents, or other adult family, to shift their lives to accommodate a student's disability, rather than using intervention strategies or targeted therapies to alter the student's behaviors. For example, parents of a child on the autism spectrum may be advised to change to a routine and schedule that is most beneficial to their child rather than trying to help the child adapt to an existing routine and schedule. Parents are often told, whether implicitly by societal norms or explicitly by friends and family, that problem behaviors are a result of a dysfunctional parent-child relationship rather than any underlying psychology (Borovoy, 2008).

One interesting phenomenon is that according to Kayama and Haight (2014), many Japanese schools are willing to remodel buildings to be accessible to physically disabled students, but do not do so until such a student enrolls. This may be taken as an unwillingness to change until forced by circumstance, or it may be the quintessentially Japanese attitude of not wanting to assume that accommodations are needed until they are requested. Kayama notes

that once a Japanese person had accepted her wheelchair, “lack of accessibility became their concern as well as hers.” (p. xi) The notion that inaccessibility is not a societal problem but a personal one is very different from American society, where the Americans with Disabilities Act mandates systemic changes in the name of accessibility.

The Japanese cultural attitude towards autism spectrum disorders, ADHD, and other behavioral disabilities is one that provides a great deal of leeway in accommodating children’s disabilities without ever acknowledging them as disabled. This construction of disability identity leads to many people with these disabilities being left out of the special education system, whether in an effort to reduce stigma by not formalizing their disability or as part of a belief that their disability is not severe enough to require accommodations.

### ***Hikikomori*: Japanese “Hermits”**

The term *hikikomori* refers to a form of social withdrawal in which an individual voluntarily retreats from the wider world to live in self-imposed hermitage, often supported by family. This Japanese phenomenon was first described in the 1970s as an epidemic of school refusal, or *futoko*, among adolescents and was later redefined in the 1990s as hikikomori (Kato et. al, 2019). Saito, the first to use the term hikikomori to describe this occurrence, defined it in 1998 as “those who become recluses in their own home, lasting at least six months, with onset by the latter half of the third decade of life, and for whom other psychiatric disorders do not better explain the primary symptom of withdrawal.” Estimates of the number of hikikomori range from .9% to 3.4% with an increase in recent years (Koyama et. al, 2010). There are support centers, both state- and private-run, designed to help hikikomori reacclimate to society (Ogino, 2004). There is a trend among mental health professionals to use terminology that describes withdrawn behaviors as a temporary state rather than an ongoing condition; this relates to the reluctance to medicalize conditions that are seen as the result of societal factors rather than biological ones (Borovoy, 2008).

There are a few cultural factors that allow for the existence of hikikomori in Japan. First, it is not only common but expected for children to live with their parents past their secondary school years and well into adulthood. This blurs the line between childhood and adulthood and independence and interdependence (Borovoy, 2008). This also goes towards explaining the gender imbalance in hikikomori (three times as many men as women have been identified as hikikomori); it is far more socially acceptable for women to retreat from society as housewives or family caretakers without being labeled. Second, the previously discussed reluctance to stigmatize children by diagnosing them with psychiatric or behavioral disabilities creates a population of adults that have never received formal treatment and may turn to social withdrawal to manage their symptoms (Kato et. al, 2019). This is particularly apparent for those with depression, social anxiety, and related conditions: the Japanese attitude towards psychiatry is very different from the American perspective. In Japan, emphasis is placed on self-reliance and community support as treatment rather than medication or therapy. Even those patients who self-report psychiatric symptoms are much less likely to request psychiatric medication as a primary form of treatment (Borovoy, 2008). Third, the technology boom of the twenty-first century allows for a person to get nearly everything they need to live via the internet- one can work, shop, socialize, and travel via a secure internet connection and a VR headset (Kato et. al, 2019; Twenge, 2017). Hikikomori are no longer forced to go into society or rely on family members for their basic needs. They can turn a tiny studio apartment into their entire world (Borovoy, 2008).



There is increasing discussion and analysis of hikikomori as a global phenomenon rather than a culture-bound syndrome unique to Japan (Kato, Tateno, et. al, 2012; Teo & Gaw, 2010). As the body of literature on hikikomori grows, clinicians in non-Japanese settings are noting patients who seem to fit the diagnostic criteria without the cultural component (Teo et. al, 2015). There is as yet no consensus on whether social withdrawal in non-Japanese settings can fully meet the criteria of hikikomori because the initial definition and analysis was wholly centered on a Japanese context. For example, a study of hikikomori-like individuals in Spain revealed a distinct difference in age at onset, with Spanish hikikomori trending older than their Japanese counterparts (Malagón-Amor et. al, 2014).

## **Conclusions**

This direct comparison of American and Japanese special education systems as analyzed through the social model of disability shows that just as disability is culturally contextual, so too is the idea of special education. Students with the same disability may receive entirely different accommodations, or no accommodations at all, in different countries. Cultural attitudes around the purpose of education (especially primary education), the root cause of mental and behavioral disabilities, and the role of legislation in education play a major role in the development of special education systems. If, as in Japan, primary school is focused on developing social-emotional skills with a classroom peer group, behaviors associated with ASD, ADHD, and cognitive disabilities are far less disruptive to the classroom environment and the student is far less likely to be entered into the special education system. If, as in the US, primary school is focused on acquiring academic skills as assessed by standardized testing, these same behaviors may earn the student a special education referral. Every aspect of a student's identity can potentially impact their experience with both the medical and education systems, and national context is one aspect that has not been fully explored in the literature.

This analysis has its limitations; one is that I am not a Japanese speaker and so had to rely on works that had been translated into English. Japan is relatively racially and ethnically homogenous when compared to the US, so I was unable to draw direct comparisons to the racial demographics of special education students in the two countries. Another is that this is a very brief overview; each aspect of this analysis has on its own enough material for a book-length examination. Finally, I was not able to perform any ethnographic research; a future version of this analysis would be greatly aided by interviews with individuals in each country with some of the discussed disabilities.

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