



STRATEGIC INTERVENTION: “BEING STRATEGIC” IN EDUCATIONAL THERAPY

Kok Hwee Chia¹,

Jennifer Erin Camulli²

¹Ed.D, Special Needs Consultant & Trainer,
Board Certified Educational Therapist, Singapore

²PhD, Inclusive Education Consultant,
Educational Therapist, Dubai, UAE

Abstract:

In the field of special education, *treatment* is a broad term and it can be divided into three categories: *intervention*, *rehabilitation*, and *management*. In the educational therapy, the main focus is on *intervention* – originally a medical term – and can be briefly defined as an act of interfering with the outcome or course especially of an individual’s challenging condition so as to prevent harm or further deterioration to the individual’s condition, or in the hope to improve the individual’s overall functioning as normally as possible. In this paper, the authors began by making a quick and brief introduction of what the term *treatment* covers and then plunged into examining *intervention*. There are three forms of *intervention*: clinical, diagnostic, and strategic. The authors have chosen to narrow their focus on strategic *intervention* based on eight guiding principles adapted from Erika Andersen’s ‘Being Strategic’ principles for every day (Part 1) and with a group (Part 2) (Andersen, 2010) within the context of a trans-disciplinary team approach to manage the challenging issues of learning, behavioral and/or emotional disruptions. Three key frameworks are involved in the strategic *intervention*: (a) the Cattell-Horn-Carroll (CHC) theory of cognitive and academic abilities (Carroll, 1993; Cattell, 1963; Horn, 1965); (b) the Model of Hierarchical Complexity (MHC) applied to human behaviors (Commons, 2007); and (c) the Feeling Wheel Classification (FWC) of feelings, emotions and moods (Willcox, 1982).

Keywords: clinical, diagnostic, *intervention*, strategic, *treatment*

Introduction

In the United States, with the 1997 Amendments to the Individuals with Disabilities Education Act (PL 105-17), the mission of alternative programs has expanded to include students with special educational needs (SEN) in addition to the education of youth that have dropped out or at risk for dropping out. These special alternative education

programs are provided to students with SEN “*whose behavior warrants special attention outside the general education setting*” (Quinn, Rutherford, & Osher, 1999, para. 1). Unlike the traditional alternative settings where students with SEN were often sent away to a special school or in a classroom taught separately from their peers without SEN, these alternative special education programs which provide alternative programming, including flexible curricula that can address the unique social, behavioral, emotional, cognitive, and vocational needs of these exceptional students within the setting of a mainstream school (Quinn, Rutherford, & Osher, 1999). This is inclusive education at its best and the alternative special education programs that are provided constitute parts of the overall educational therapy catering to students with SEN.

1. Educational Therapy

Educational therapy is recognized by the World Health Organization and has been listed in the International Classification of Disease-9th Edition-Clinical Modification (ICD-9-CM) (World Health Organization, 2009) with the ICD-9 code 93.8-Other Rehabilitation Therapy under the sub-code 93.82-Educational Therapy, which involves (i) education of bed-bound children and (ii) special schooling for the handicapped. It is, therefore, an alternative form of education for children who are unable to attend normal school like their peers without SEN.

In the field of educational therapy, the term *treatment* refers to the delivery of adequate measures which are modeled to alleviate a psycho-educational and/or psycho-behavioral condition. According to Aaron (1989), treatment refers to “*specific efforts and techniques utilized to improve*” (p.219) the problematic learning and/or behavior of an individual client with whom an educational therapist is currently working.

In general, treatment (as shown in Figure 1) can be divided into three categories: (a) Intervention; (b) Rehabilitation; and (c) Management.

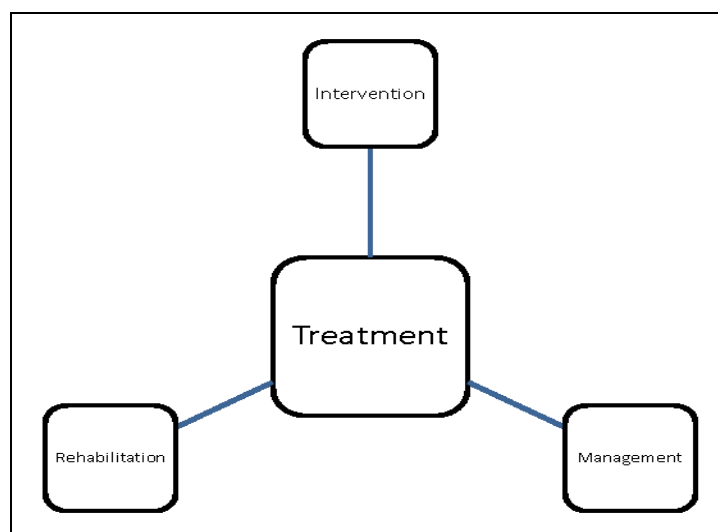


Figure 1: The Three Types of Treatment

First, the intervention is defined as an approach/method/strategy to deal with the issues and an action on part of an educational therapist for the client and his/her problems relating to learning disruption (LD), behavioral disruption (BD) and/or emotional disruption (ED). It is guided by the following five factors: (a) the nature of the problem; (b) the selection of an educational therapist; (c) the therapist's professional orientation; (d) the setting where the intervention session will be held; and (e) the willingness and ability of the client to proceed with the intervention session. There are three types of intervention: clinical, diagnostic and strategic. This is the main focus of this paper but we shall discuss them later.

Second, the rehabilitation is defined as the process of helping and training an individual client to recover from or cope with LD/BD/ED conditions or handicaps, including challenging physical, emotional or behavioral issues, so that he/she can return to the normal state when he/she was before.

Third and finally, the management in educational therapy refers to "*efforts undertaken to help an individual client cope with learning and/or emotional-behavioral demands but not necessarily to improve **learning/emotional behavior** itself*" (Aaron, 1989, p.219; words in bold are added by the authors of this paper).

1. The Three Types of Intervention

As mentioned in the Introduction, intervention can be divided into three different types: clinical, diagnostic, and strategic (see Figure 2). Here we shall provide a brief description for each of the three types of intervention, but our main focus will be on strategic intervention.

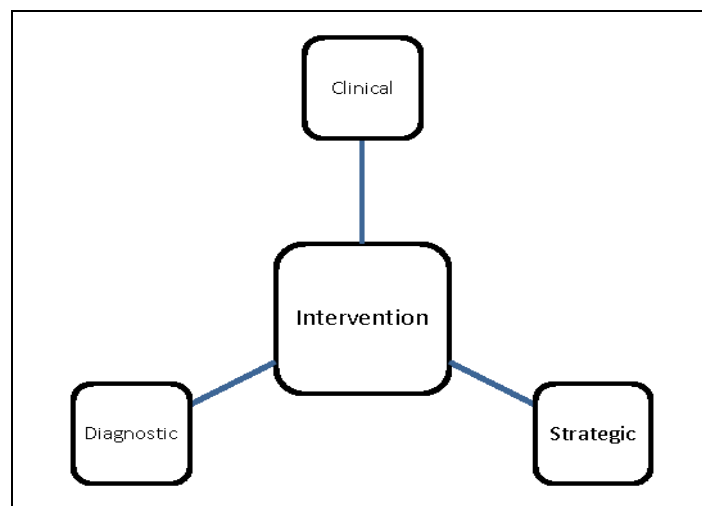


Figure 2: The Three Types of Intervention

Clinical intervention is one form of clinical teaching/learning. Bradford (1958) defined clinical teaching-learning process as "*a human transaction involving the teacher, learner and learning group in a set of dynamic interrelationships. Teaching is a human relational problem*" (p.135). The definition is certainly quite old and ambiguous, and it does not indicate observation or evaluation of symptoms to plan for a targeted outcome.

Currently, there is no definition of clinical teaching-learning process in special education. In this paper, we have decided to define clinical intervention as a professional community-based treatment approach designed for the purpose of identifying, resolving and documenting the key issues of LD/BD challenges of a client with special needs. Its main goal is twofold: firstly, it is to seek improvement in the client's well-being in terms of positive learning/behavioral outcomes; and secondly, it also seeks to improve the quality use of intervention strategies with the client concerned. This means that as a professional activity, the clinical intervention must be undertaken by a certified or registered educational therapist directed toward improving quality use of intervention strategies and resulting in a recommendation for a change in the client's treatment, means of clinical assessment or intervention-taking behavior.

Diagnostic intervention is a term borrowed from Schein (2016), whose *"insights on the level of relationship management are also applicable in the context of educational therapy"* (Galoppin, 2011, para.1). Schein (2016) used the term 'diagnostic intervention' to indicate that a consultant (i.e., an educational therapist) should be aware of the fact that each contact he/she has with a client is an intervention (see Galoppin, 2011, for detail). Adapted to educational therapy, a diagnostic intervention is a good way to involve everyone in a professional therapy (or intervention) team by asking them relevant questions about the present state, learning relevant facts about possible challenges to treatment, influencing the client's perspective/thinking and getting the client to cooperate during each treatment session (Galoppin, 2011). Educational therapists need to recognize that the questions they ask may influence the perspective/thinking of the client (as well as the parents/guardians of the client) and members in the therapy/intervention team. In other words, once *"[T]he whole dynamic of questions, reactions and assumptions is put in motion ... we have started our diagnosis"* (Galoppin, 2011, para.3): e.g., who is the consultant/educational therapist that is going to work with the client? Why is the client or client's parents/guardian asking those questions? Why is the client seeking help from this educational therapist and not others? According to Galoppin (2011), the failure to frame the purpose of an interview by an educational therapist to the client or client's parents/guardian, *"these questions will start to lead their own life in the back channel. Therefore, it's crucial to have ... act together and make sure ... have a conversation about the conversation before actually starting it (i.e., treatment)"* (para.3).

Strategic intervention is 'being strategic' in carrying out an intervention. This phrase is borrowed from Andersen (2010), who is a leadership coach and the founder of Proteus International, a consulting, coaching and training firm. According to Andersen (2010), *"[B]eing strategic means consistently making those core directional choices that will best move you toward your hoped-for future"* (p.5). In the context of educational therapy, this means an educational therapist is making a choice-based decision to direct his/her treatment plan for the client with whom he/she is working toward the target goal as set in the plan. We shall elaborate more about it in the next section.

2. The Strategic Intervention: 'Being Strategic' Guiding Principles

The word 'strategic' in strategic intervention is borrowed and adapted from the seminal work of Andersen (2010) on how to be strategic in terms of planning for success, out-thinking the competitors and staying ahead of change. In the context of educational therapy, being strategic can be further divided into two parts. The first part concerns the guiding principles for an educational therapist being strategic every day. The second part provides the guiding principles for the educational therapist being strategic with a group of professionals that he/she is working collaboratively.

The group of professionals can be poly-disciplinary, i.e., multi-disciplinary, inter-disciplinary or trans-disciplinary. According to Stember (1991), there are five different disciplinary intervention team approaches:

- Intra-disciplinary intervention team approach: Team members work within a single discipline;
- Cross-disciplinary intervention team approach: Team members view one discipline from the perspective of another;
- Multi-disciplinary intervention team approach: Team members from different disciplines work together, each drawing on their disciplinary knowledge and skills;
- Inter-disciplinary intervention team approach: Team members integrate their respective knowledge and methods from different disciplines, using a real synthesis of approaches; and
- Trans-disciplinary intervention team approach: Team members create a unity of intellectual framework beyond the disciplinary perspectives.

According to Chia (2014), Jensenius (2012), Choi and Pak (2006), there are differences among the five disciplinary intervention team approaches. The three most commonly preferred ones that fall within the same continuum in collaborative teamwork approach (Choi & Park, 2006) are as follows:

- a) The multi-disciplinary intervention team approach draws on knowledge from different disciplines but stays within their boundaries;
- b) The inter-disciplinary intervention team approach analyses, synthesizes and harmonizes links between disciplines into a coordinated and coherent whole; and
- c) The trans-disciplinary intervention team approach integrates the natural, social and health sciences in the context of humanities, and transcends their traditional boundaries (Choi & Pak, 2006).

Zeigler (1990) has summarized these five different disciplinary intervention team approaches into the following Figure 3:

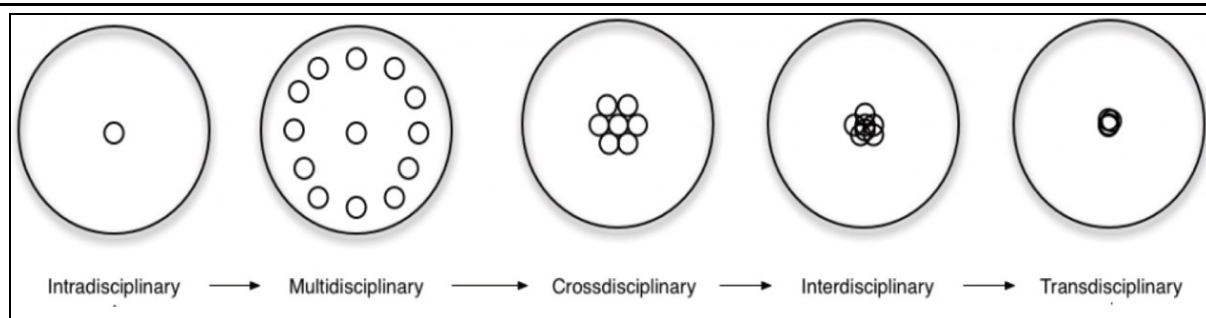


Figure 3: The Five Disciplinary Intervention Team Approaches (Zeigler, 1990)

In a poly-disciplinary intervention context (be it inter-, cross-, multi- or trans-disciplinary), an educational therapist cannot work in isolation from the other professionals or paraprofessionals, and certainly, not without the client and the client's family. Chia (2010) has put forth three reasons why that are so and these have become the guiding principles for the treatment responsibility of an educational therapist. These three principles of treatmentⁱ are briefly described below.

The first principle known as the Principle of Targeted Treatment states that “[I]f you know about the disability, disorder or problem and are also mindful of how much you know about its variant and non-variant traits, you are in a better position to prepare a good treatment with no fear of failure” (Chia, 2010, p.124). It is important for an educational therapist to work collaboratively with other professionals such as teachers, counsellors, allied educators and psychologists who can provide useful information used in identifying issues pertaining to learning/behavioural disruptions or other related challenges which may include low motivation and poor attitude towards learning.

The second principle known as the Principle of Symptomatic Treatment states that “If you are ignorant of the disability, disorder or problem but are aware of how much you know about its variant and non-variant traits basing on your own observation and dealing with the client, your chances of success or failure in the treatment are equal” (Chia, 2010, p.124). Whether or not an educational therapist is trained or equipped to work with an individual diagnosed with dyslexia, for example, it is good if the educational therapist recognizes the signs and symptoms that are affecting the reading performance of that individual. In this way, by treating the symptoms (e.g., poor word recognition and erratic spelling) using known conventional strategies such as syllabication, onsets and rimes and word families, the educational therapist can still help the individual to learn to decipher words and eventually learn to read on his/her own.

The third and last principle known as the Principle of Sure Chaotic Treatment states that “If you are ignorant of the disability, disorder or problem and are also unaware of its variant and non-variant traits, **and you have not even worked with the client**, you are sure to fail in treating the condition. At all cost, this last principle should serve as a warning to those who are not well informed or trained to help children with disabilities, disorders or problems to offer any ill advice or poorly designed treatment that can become detrimental to clients with learning & behavioural challenges” (Chia, 2010, p.124; words in bold are additional). In this

ⁱ The terms *treatment* and *intervention* are used interchangeably here.

instance, it is better for a collaborative intervention team approach because there will be at least someone among the group who knows the condition and able to take the lead to manage the case properly.

Part 1: Being Strategic Every Day

Andersen (2010) has divided 'being strategic' approach into two parts. The first part concerns "*being strategic every day*" (p.10) and consists of nine guiding principles. Using "*the idea of building a castle on a hill as a metaphor for the process of thinking strategically*" (p.9-10), Andersen (2010) highlights an important point that a castle built on a hill has the strategic advantage over potential attackers and that also provides an excellent view from a higher position to see in many directions. Using the metaphor of a-castle-on-a-hill, she provides the following guiding principles: (a) defining the challenge: how can we ...; (b) what is: pulling back the camera; (c) what's the hope: reasonable aspiration; (d) what's the way: facing the facts; (e) what's the path: first, then asphalt; (f) the art of crafting strategy; (g) tactics that work; (h) building on success; and (i) the castle of you (see Andersen, 2010, for more detail, p.9-14). The second part concerns "*being strategic with a group*" (Andersen, 2010, p.14) and consists of the following five guiding principles: (a) inviting others into the process; (b) crafting a strategic vision; (c) the art of facilitation; (d) strategy as a way of life; and (e) castle building for fun and profit (see Andersen, 2010, for more detail, pp.14-17).

As the castle-on-a-hill is not a clear (but remains foggy) metaphor, the second author preferred to use a different metaphor taken from Quong and Walker (2010). In their illustration, the metaphor for the strategic leadership is that of principal as a car driver, someone who has an image of where they want to end up, but who does not have a GPS to lock-step their journey. A leader is a driver who is willing to take different turns and different roads to take into account changing road and traffic conditions and to improve the experience for the passengers. The driver keeps checking the dashboard of the car for indicators and gauges that tell of the state of the car, but he or she also constantly scans the road ahead for whatever may appear around the next bend. This will provide the readers a better, if not, clearer, understanding, and they want to use this metaphor instead.

Nevertheless, we have agreed to adapt the guiding principles from Andersen's (2010) first part and designed the following client-centered procedure for strategic intervention in educational therapy:

Principle #1: Identify and define the client's problem in terms of learning disruption (LD), behavioral disruption (BD) and/or emotional disruption (ED). The main aim is to understand the client's condition and what his/her crucial needs.

Principle #2: Recognize the client's personal qualities and disposition and his/her current situation. This provides the educational therapists the main context (which may consist of several settings) upon which to give a more holistic picture of the client's issues of concern in terms of LD, BD and/or ED.

Principle #3: Provide a tentative prognosis (positive or negative) based on the available information relevant to the issues of concern (in terms of LD, BD and/or ED) given by the client or the client's caregivers/guardian. An educational therapist must

always hold a formal consultation session with the client and/or the client's caregivers/guardian to explain the diagnosis of the condition and/or also to provide a possible prognosis based on the available information provided.

Principle #4: Identify the obstacles that will hinder the intervention process and affect the intervention outcomes. In this regard, the educational therapist must keep a clear perspective: (a) to treat every condition (acute or chronic) with care; (b) to recognize the limitations of available resources to work with the client as well as the professional knowledge and skills of the educational therapist; and (c) to know and understand the restriction that may be imposed on the intervention as the result of the client's condition.

Principle #5: Come up with the key foundational decision about how to approach this massive undertaking to treat the client's condition in terms of LD, BD and/or ED. The educational therapist must be well-versed in his/her understanding and application of the Cattell-Horn-Carroll theory (commonly abbreviated to CHC), which is a prominent psychological theory on the structure of human cognitive and academic abilities (see Schneider & McGrew, 2012, for detail), the Model of Hierarchical Complexity (MHC) of the client's behavioral issues (see Commons, 2007, for detail), and the Feeling Wheel Classification (FWC) of the client's feelings, emotions and moods (see Willcox, 1982, for detail). Unfortunately, it is not within the scope of this paper to delve further on CHC, MHC and FWC as these are more complex concepts that cannot be explained briefly in a few lines. Readers are encouraged to read up the relevant papers mentioned in the citations here.

Principle #6: Design an appropriate individualized intervention plan/program to meet the client's needs using the AMST procedure which is: (a) what Approach is to be adopted: system-based or person-centered; (b) what Methodological procedure is to be followed, e.g., the 3-period lesson in the Montessori Method; (c) what Strategy is to be used in order to meet the client's learning/reasoning/thinking style, e.g., inductive (bottom-up), deductive (top-down) or abductive (starts with an observation and then seeks to find the simplest and most likely explanation); and (d) what Tasks or activities to be carried out with the client in order to meet his/her needs in terms of LD, BD and/or ED.

Principle #7: Plan tactically for the intervention by considering the following three key *wh*-interrogatives: (a) *who* is to be involved in executing the intervention plan; (b) *what* exactly needs to be done; and (c) *when* to implement each part of the intervention plan so that it will flow through smoothly to the benefits of the client in terms of his/her LD, BD and/or ED.

Principle #8: Evaluate the outcomes at the end of the intervention period and re-position the AGO of the intervention program/plan, i.e., one annual Aim, the two semester Goals and four academic term-based Objectives in terms of LD, BD and/or ED stated in the intervention plan specially designed to meet the client's needs. This last principle #8 can be done by the educational therapist himself/herself alone or together with other allied professionals who are members of the trans-disciplinary intervention team working on the same case.

Figure 5 (see below) is a summary of the eight guiding principles for 'being strategic every day' in the strategic intervention. The first three principles concern the client's involvement. The fourth principle focuses on the obstacles that hinder the intervention process. The fifth and sixth principles concern the involvement of an educational therapist. The seventh principle concerns the involvement of other allied professionals working collaboratively with the educational therapist. The eighth and last principle can involve on the educational therapist alone or the intervention team that is working with the client (see Figure 7).

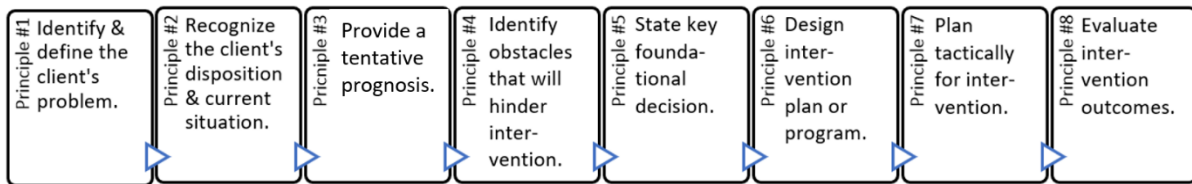


Figure 5: The Eight Guiding Principles for 'Being Strategic Every Day' for Strategic Intervention

Part 2: Being Strategic with a Group

Educational therapists constitute one of the many groups of trained professionals working with individuals with special needs; the other professional groups being the speech language therapists or pathologists, occupational therapists, psychologists, counselors and other allied therapists (e.g., music therapists). For a good strategic intervention plan or program to work well, it must involve other professionals who must be able to work collaboratively with each other and there should not be any inflexible form of hierarchical chain of command as it will only lead to politicking and unhealthy clashing of professional ideologies. For a group of professionals to work collaboratively together in providing adequate intervention, we strongly recommend the trans-disciplinary intervention team approach under the administration of a capable and fair case manager (see Appendix A for the role of a case manager).

Andersen (2010) has introduced five guiding principles for this second part on "being strategic with a group" (p.14). Like the first part of "being strategic every day" (Andersen, 2010, p.10), we have also adapted the guiding principles from Andersen's (2010) second part and designed the following client-centered procedure for strategic intervention in educational therapy:

Principle #A: Invite other allied professionals into the trans-disciplinary team so that everyone can learn from each other as well as to offer ideas to design or plan a better intervention program.

Principle #B: Design a strategic intervention program based on a combination of conceptual fit, practical fit and evidence of effectiveness fit (see Figure 6) in order to meet a client's learning, behavioral and emotional needs. This process model of selecting best fit prevention interventions is adapted from the model found in *Identifying and Selecting Evidence-Based Interventions* (a revised version of Guidance Document for the Strategic Prevention Framework State Incentive Grant Program) published by the US Department of Health and Human Services (USDHHS) (2009). Briefly, the conceptual fit asks the question: how relevant is the intervention to the

client's needs? The practical fit asks the question: how appropriate is the intervention to meet the client's needs? The evidence of effectiveness fit asks the question: how effective is the intervention to benefit the client?

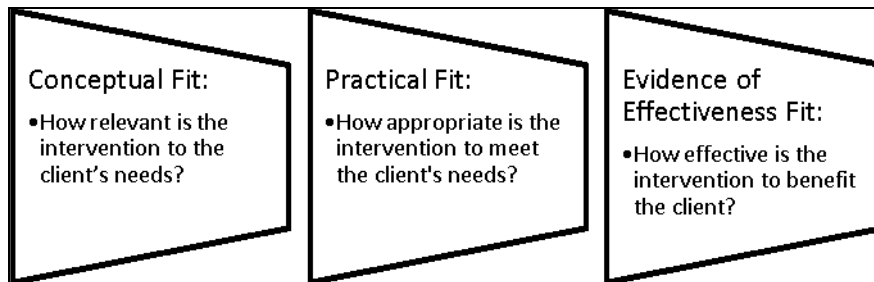


Figure 6: Three Phases of Fit in the Treatment Plan Design for ASD

Principle #C: Acquire skills in interpersonal relations and professional services for supporting the intervention team to move through the intervention process well.

Principle #D: Keep the strategic intervention approach as professional way of service accountable and responsible to the clients with whom they are working as a team.

Principle #E: Discuss how best to facilitate: (a) a repositioning meeting for all the members in the intervention team after the first three months of three 1-hour-sessions-per-week intervention, then another repositioning meeting after the next three months of two 1-hour-sessions-per-week intervention, and the last repositioning meeting for the final three months of 1-hour-session-per-week intervention. The frequency of the intervention sessions is arbitrary and we are using this intervention schedule as suggested here at an early intervention center where we serve as its external consultant; and (b) a full 'reboot' meeting after nine months of intervention to help the team reflect on and learn from what has been done and to revise the original intervention plan or improve the intervention program as needed in order to move toward the one annual aim, two semester goals and four term-based objectives as the set targets in terms of meeting the client's learning, behavioral and/or emotional needs.

Figure 7 (see below) is a summary of the five guiding principles for 'being strategic with a group' in strategic intervention.

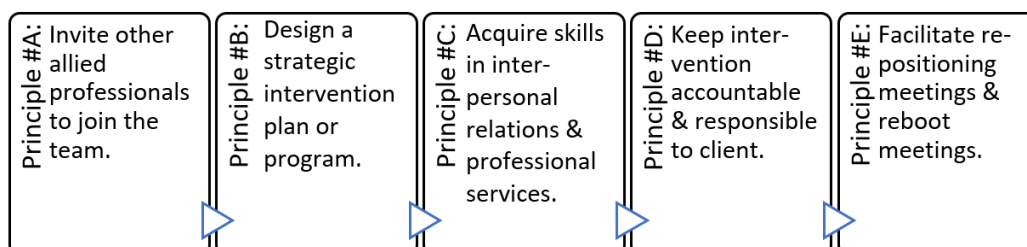


Figure 7: The Five Guiding Principles for 'Being Strategic with a Group' in Strategic Intervention

3. Conclusion

When the two parts of 'being strategic' are placed together within the context of strategic intervention (see Figure 8), it highlights the need for educational therapists (not only to work alone) to work collaboratively with other professionals as well as in consultation with them in a trans-disciplinary intervention team supported by a case manager, whose key role is to help in monitoring the intervention process (based on the agreed intervention plan or program) as well as evaluating its progress (i.e., a client's progress in terms of learning, behavior and/or emotion) over a period of time (e.g., from nine months to a year).

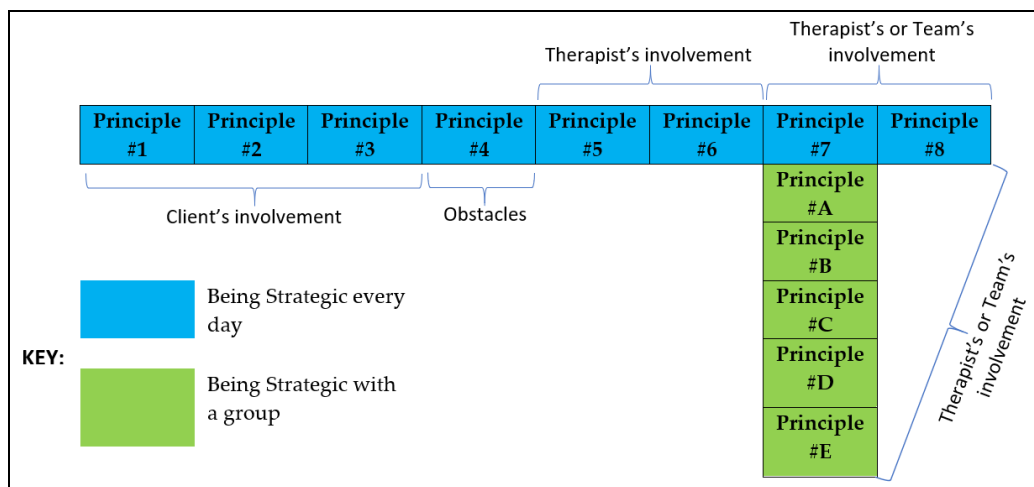


Figure 8: Combination of the Eight 'Being Strategic Every Day' Principles and the Five 'Being Strategic with a Group' Principles

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