

## *Development of Schools for Students with Mental Disabilities*

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The dominant approach for working with people with mental disabilities is characterized by the terms ‘safekeeping’ and ‘development’. These pedagogical concepts focus on the deficits of the people with mental disability, and on the improvement of their condition.

This approach is rooted in a long tradition that is in turn based on the idea that mental disability is an *essential quality* in human beings.

Since the 1960s, the SfG has based its structure and organizational guidelines on the idea that mental disability is an essential quality.

Now, in light of new theoretical and practical developments in the field of disabilities, changes in SfG’s structure and guidelines are urgently required.

**In the following I will:**

**First** quickly summarize the basic assumptions under which the SfG has been working, and the consequences of these assumptions

**Second** discuss the pedagogical and philosophical basis of the new concept underlying work in the field of disability

**Third** point out the potential organisational and Conceptual consequences of this concept

**Fourth** introduce the themes and areas of work currently relevant to schools for students with mental disabilities

I. **Previous understandings and leading concepts in work with students with mental disabilities**

After National Socialism, the special needs field could have started with a new beginning, including a reflection on the failure and guilt of the past. Unfortunately, this was not the case. Instead, most of the physicians and teachers continued to work in the same psychiatric clinics and institutions in which they had worked under National Socialism. The structure of the psychiatric institutions also remained

basically unchanged. As a rule, most of the severely mentally handicapped children and young adults were diagnosed as ‘nursing cases’ and locked away in institutions. Their treatment was characterized by medication, objectification, and infantilization. That is, they were treated as ‘cases’ and denied any right to self-determination.

The practice of locking away the mentally handicapped in psychiatric clinics continued to be the norm for some time. The first moves away from this norm began in 1950, when parents of handicapped children founded the initiative “Life Support for the Mentally Handicapped Child”. They demanded special nursery schools, as well as primary and high schools for their children, especially for those with severe handicaps. This was a significant breakthrough because until then all children with mental disabilities had been labelled as *unable* to learn.

As a result of this breakthrough, every Federal state established expansive schooling programs and developed plans for special schools for the mentally disabled during the 1960s and 70s. Schooling then became obligatory for children with severe disabilities, a law that remains in effect.

However, within these developments were weak points. Special teachers were responsible for educating the pupils, and did so with the goal of adapting them to the so-called ‘normal’ world. This often resulted in the development of ‘isolated careers,’ which began with their admission into special nursery schools and continued through their placement in special housing. It became increasingly clear that this approach separated and isolated the handicapped from the ‘normal population’.

For the purposes of today’s talk, it is useful to outline the understandings underlying these practices. It should be kept in mind that this approach to mental disability developed when social and political policies were shaped by economic recovery and the concept of subsidies.

All measures were based on ‘intelligence tests’

- To justify the creation of special institutions to educate individuals with mental handicaps

- With the result that people with special needs were categorized as ‘less gifted’ and were
- grouped according to their deficits

This categorization was based on the following premises:

- **one** The emphasis lay on the *specific*, meaning that the mentally handicapped were conceptualized as *essentially* different from others.
- **two** The disability was understood as an *attribute* of the individual, similar to having an impaired heart, green eyes, being short or overweight
- **three** The categorization was *impairment-specific* and *deficit-oriented*. The deviation or abnormality was emphasized, and seen as the inferior duplicate of the normal.
- **four** The disability was generalized and understood as afflicting the whole person.

Consequences of this approach:

- A focus on an implied “handicapped reality” through special nursery schools, schools, workshops, housing and so on  
= the schools educated them to live separately; they failed to help the student plan for a future work, home, social, and family life
- **Infantilization:** their needs, wishes and potential were not taken seriously. Likewise, their status as adults was not acknowledged  
= the schools ignored their wishes, needs, and abilities because they were seen as incapable of having good ideas about, or the ability to imagine, what their lives should be
- **Gender neutrality:** their sexuality was denied, and with it their right to partner and become a parent.  
= The schools ignored their responsibility to prepare students with mental disabilities for their gender roles. They also failed to prepare these students for establishing partnerships, experiencing sexuality, and becoming parents
- **Lack of self-determination**  
= the institutions denied the students the right to vouch and speak for their own interests, needs and activities

- **Discrimination as ‘afflicted existence’**  
= Politically, their existence was questioned in that their existence was considered “afflicted”
- **The special needs school system had very little contact to other systems**  
= Society was closed to persons with mental handicaps, and they experienced discrimination that came from the sense that their presence a threat  
The schools were also closed to society, thereby losing the opportunity to gain help from others

## **II. Leading developments in schools for students with mental disabilities**

**In the 1970s, work with the mentally handicapped was focused on the ‘normalization model,’ originally developed in Scandinavia. This model demanded that people with mental disabilities be granted the same comforts and conditions available to the rest of the population, for example, a normal day, a separation between the living space and work and leisure times, and the possibility of career development. It did *not* imply an education designed to help these individuals lead an inconspicuous life, or to help them conform to “normal” standards.**

**The ‘integration model’, developed in Italy, also gained in importance during this decade. This model called for the use of all educational and pedagogical measures aimed at a greater participation in, and integration of, people with mental disabilities into society. These measures included, for example, nursery schools, housing, employment and leisure activities.**

**More recently, principles from the American Independent-Living and Empowerment Movement have been adopted. This movement calls for more democracy, emancipation, and self-determination for handicapped citizens.**

**The “assistance concept” is based on these same principles. Assistance services are no longer oriented on therapy or support for adults with mental disabilities, but rather on enabling them to manage daily life as they themselves desire. In other words, the focus is on enabling them to choose their own individual lifestyle. Assistance within the supportive relationship means that the assisting person helps to realize the**

assisted's own hopes and goals. This requires competence in listening, interpreting, and in the analysis of non-verbal expressions. It also requires a readiness and an ability to support the *individual lifestyle* of the person with the mental disability.

Schools, too, are to be restructured. It has been demanded that schools open up to the students with special needs. This development includes

- **Basic education, which based on the 'living-world' (=Lebenswelt) of the student (ICF-Version der WHO; 2002)**  
Schools have to answer the question: "What qualifications are necessary for a student with special needs to develop an individual lifestyle in participation?"
- **Schools support employment within a normal working life through assistance and 'on the job training'**
- **Schools initialise 'Living-at-Home Rehearsals' to enable adults with mental disabilities to live independently. This, in turn, helps them avoid living permanently in a group home**
- **Schools support self-determination and decision-making abilities.**
- **The development of a diagnostic system that works with educational activities to strengthen children's talents**
- **Discussion of limitations and weaknesses so that a need for help can be articulated**
- **Explore gender roles, learn about sexual violence, develop a peer group, and establish an emancipated sex education program.**
- **A more open attitude (communication with other systems) on the part of schools in the areas of working, living, leisure times, friendship, sexuality, parenthood...**

### **III. The current view of special schools for students with special disability**

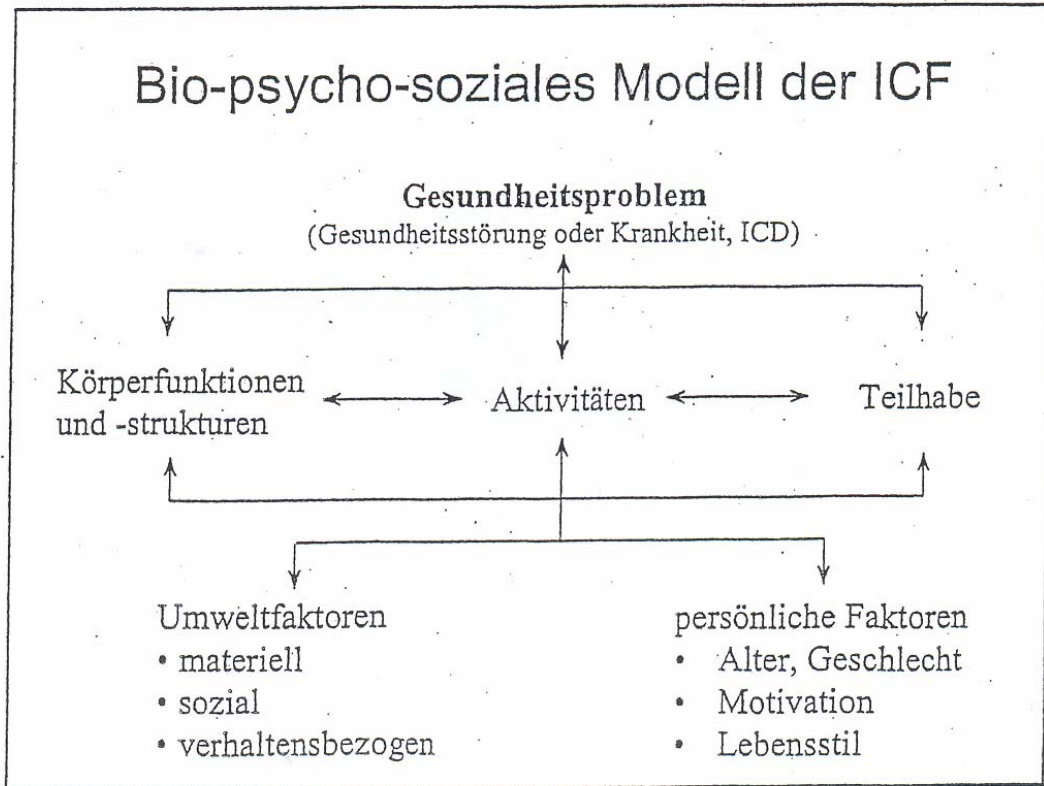
Pedagogic workers for the handicapped, pressure groups, and educational authorities are currently preoccupied with the question of whether we can see mentally handicapped people fundamentally

differently. Drawing on the World Health Organization's ICF (International Classification of **F**unktioning), mental disability is no longer understood as something that one *has* like green eyes or an impaired heart. Nor is mental disability something one *is* like short or thin. Mental disability is also not a health disorder or a mental illness. Today it is understood as a *functional condition* that begins in childhood and that is characterized by a limited intelligence and ability to adjust to one's surroundings.

The type of handicap and the support a person with a mental handicap receives primarily determine her or his ability to participate and the activities that can be performed.

Summary: The essential difference from the previous view is the shift from the *person* to the *sphere of living*, the so-called 'Lebenswelt'. It is in the *sphere of living* that a person needs special support and help. To provide this, a more precise knowledge of the competences of a person with limitations is necessary.

Abb.: Multidimensional and relational view of mental disability



The term ‘relational view’ suggests that mental disability is a relationship to the standards, cultures, expectations, requirements, systems and structures in which people live. If these expectations, standards and ideas change, then the understanding of, and contact with, the mentally handicapped changes as well.

We therefore refer to the *condition* of being mentally handicapped – where the term “condition” implies that the experience of being mentally handicapped is largely shaped by the context in which the individual lives. In other words, the experience of interacting with institutions, systems, other people, and with her - or himself is largely shaped by the existence and nature of support for the individual. Similarly, the presence and nature of support shapes the person’s ability to actively and competently take part in society.

This view acknowledges that people live within, and rely on, a particular constellation of relationships and contexts. We therefore also have the ability to use, shape and change this constellation, and have the right to be supported in doing so. It is thus clear that the disability is not the whole person. Rather each person is a social entity living within relationships that determine his or her possibilities in life.

Adopting this approach requires schools for students with mental disability to open up to questions such as:

- what strengths and weaknesses (a person has that shape his or her integration into, and participation in, the community - for instance social, cultural, religious, leisure, or professional activities.  
= **Participation opportunities**
- What kind of social network is available? Does the person have friends? What is the school atmosphere like? Where will this person work, and can she/he receive assistance and support there? What is the person’s background? That is, what social structures and community services have played an important role in her or his life?  
= **Environmental or contextual factors**
- What do I know about the person’s biography? What is her/his religious affiliation? What role does her or his gender play?

**What is her or his cultural background? What behavioural strategies and patterns does she/he have? In what economic, psychophysical, legal, social and symbolic life conditions does she/he live?**

**= Personal factors**

- **How does she/he perceive, experience, and process a disability despite, or because of, assistance and support Does she/he experience her/his life situation as an organized and consistent whole, or as unstructured, perhaps even as meaningless (is there a sense of coherence)?**

**= Experience of the limitation**

- **With which traumas, injuries (e.g. visual, auditory, physical, brain), and illnesses does the person live? What behavioral patterns has she or he adopted?**

**= Body function**

- **Does supportive help make perception, communication, mobility, self-support, and interaction possible?**

**= Activities**

**We can say that all these perspectives are in reciprocal relationship to each other. They characterize human existence as we know it. However, to refer to Foucault, our current view must not be seen as a result of great human progress. History teaches us to be careful with concepts about human beings because they always carry the seed of error. But these current views change the concepts and the structure of special schools for students with mental disability and give them a chance for a life characterized by active participation.**