„**D**ialogue-**C**entred, **S**ubstitutive, **C**o-operative **A**ction **T**herapy (DCSCAT)" or: Nobody is „Beyond Therapy" and „Incapable of Social Participation" (a Basis Therapy)

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1. Problem Orientation

The presentation of "Dialogue-Centred, Substitutive, Co-operative Action Therapy (DCSCAT)" -a Basis Therapy, here in the form of its first publication, can only be carried out in a programmatic way that is also limited to only a very few aspects which are nevertheless central to the concept of the work.[1] Gaining an adequate account of this working model in its foundations, its theory and practical applications will have to remain reserved to some extent to the planned book project, whose parameters will also offer to unfold DCSCAT in the mirror of the theory construction possible today in relation to people with severe impairments, with „deep-reaching developmental disorders" and – as the newest redefinition „gallantly" formulates- with „challenging behaviour". In addition, it will offer to portray DCSCAT in relation to the common working methods used in work with these persons. By way of introduction here, however, only a „picture" can be provided of the outward form of the working methods, and of those aspects crucial to them. The limitation to these aspects is also owed to the complexity of the work's approach**,** which does not allow for arbitrary minimisation without facing the danger of reductionistically falsifying and interpreting it in an exclusively phenomenological manner. To be expected here, then, is a rough approach to the subject matter.

The function of the working methods of DCSCAT that I have developed can be those of a basis-therapy but also of a conception of crisis-intervention for pedagogically founded processes such as prevention (for example also in the forms of face-to-face support and teaching). In working toward a presentation, the comments made in this work about these working methods refer first of all to the structure of the processes with which we try, by regaining or creating a dialogue with a person, to come into a context of co-operative action in which I see the „dialogue" as integrated in the same way as forms of interaction and communication. When speaking of the aspects involved in gaining basic components of a co-operative action, I tend to speak of a basic therapeutic process, when speaking of the aspects of learning which sets off development, of a pedagogical process. For a preliminary orientation in this context of description, I would programmatically summarise:

- Pedagogy and therapy are „means" of organising learning and action fields.
- Crisis intervention is required when the „*life plan*" of a person is broken apart, meaning that a circumstance has entered the person's life which endangers or overloads her own existence or which collapses or makes very destructive all social relationships. DCSCAT aims thereby to create the minimal conditions of co-operative action and must be oriented toward a therapy which develops itself out of this.
- „Therapy" describes the process whereby a new *"life perspective"* is found and constructed ***together with*** a person - in the sense of a biography-related process of her „rehistorisation". If this has been established, the pedagogical process now comes to the forefront.

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1 A slightly modified preprent of this article, based on a lecture given at a meeting of the Bremen Luria Socierty can be found in „Mitteilungen der Luria-Gesellschaft 7/8(2000/2001)2/1, 5-35, under the heading „Substituierend Dialogisch-Kooperative Handlungs-Therapie (SDKHT)" - Aspekte ihrer Grundlagen, Theorie und Praxis". Further, a discussion related to a particular case, along with other articles, can be refered to under FEUSER, G.: Ich bin, also denke ich!" Allgemeine und fallbezogene Hinweise zur Arbeit im Konzept der SDKHT". In: Behindertenpädagogik 40(2001)3, 268-350

- „Pedagogy" describes the process of accompanying a person in the realisation of her *„life plan"* throughout all of her developmental and life stages.
  Crisis intervention, therapy and pedagogy are
  - oriented toward the fundamental dimensions of the human being as a biological-psychological-social unity and
  - thereby are connected to the person's exchange with both her material and personal world, that is to ***„dialogue"***. Dialogue, in the context of interaction and communication, can only be realised in social co-operation, which in its own right makes the setting of a common goal or the production/design of a product necessary; a „common objective".
- „Prevention" describes measures to secure social and financial conditions in the areas of health, social affairs, and education, which enable the structuring of the life and learning fields in which an extensive and secure personality development can take place.

In clarifying some aspects, I refer predominantly to the work with people who, with the background of a „deep-reaching developmental disorder" (for example Autism), display behaviours that are severely self-injurious or also aggressive or destructive. DCSCAT is, however, also the foundation for work with people with severe impairments, such as, coma, waking coma (apallic syndrome) and severe mental disabilities and with those in the border areas of disability and psychosis. In virtually all cases, one deals here with life stories that have been marked by often decades of withheld education, heavy hospitalisation, social deprivation and a high degree of isolation. The consequences of social disappointments and psychological damage which would have caused considerable psychological trauma can especially be seen in the cases of those people for whom we must make the decision toward hospitalised work because working with them as outpatients or on an advisory assistance basis seems no longer helpful, that is, does not seem appropriate under the given conditions. As far as the organic impairments are at all provable or traceable as the primary factor of the disability, they diminish in their importance under the effects of the resulting social consequences.

With DCSCAT, we try to find ways that enable us to come out of the problems »with« the concerned person, problems in which this person is caught in the same way as the assistant. The problems are predominantly those which we have caused the concerned individuals through the consequences of longstanding professional and personal powerlessness toward them, namely through extremely restrictive measures of mechanical and/or pharmacological prostration and isolation in unattractive rooms which have blocked their ability to perceive and act and therefore also their central processing and psychological development. These measures, once put into effect, are the essential source of those behaviours which are supposedly being adequately treated with none other than these measures, under the goal of bettering or completely overcoming them. This issue, with its backdrop of the failure of remedial and special education and psychiatry as well as psycho-therapeutic measures toward these people, is practically not addressed. There is far more a tendency to condemn the attempts which have been made with people to move away from these restrictive and aggressive therapeutic measures and their "mystification" through "rehistorisation" (Jantzen et al. 1996), rather than condemning primarily the practices which have led people into such states without leaving them a chance of finding another way.[2]

The clientele we work with is characterised by people who are considered „beyond therapy" and who have been „given up on". I have been told that many of the people we have worked with, of different sex, age (from age 3 to 45) and of many different nationalities were, among other things, „therapy-resistant", „incapable of rehab", „cases for nursing", „self-destructive",

2 See here the articles of AK Psychoanalyse und Geistige Behinderung, from FEUSER, RÄCKER and DONKER in the lournal „Behindertenpädagogik" 40(2001)3, which are written in connection with a ARD-documentary with the title „Michaelas letzte Chance?", which was broadcasted on 02.08.200

„dangerous to strangers", in short that they were „incapable of social participation"- certainly the worst judgement that can be made of a person. So it was also written in many files kept about these people as a diagnosis or conclusion from what had, in part, been years of continual efforts which had come to no avail or worse, which had seen only a considerable worsening of the condition or behaviours. In relation to those people receiving neuro-rehabilitation it was said, with reference to special imaging of their brain activity, that they would not be able to live with such a condition of the brain, that they were already dead, that there was nothing which could be of any perceivable help to them, and thus that the necessary life support systems were to be switched off.

If now the efforts taken toward this group of persons, efforts often representing the total sum of the commonly recommended treatment measures, do not lead to the desired results, even if they prove to have been applied professionally and be it simply that the clients become less noticeable and will no longer cause any unacceptably high costs, the clients are left alone. This means that one removes oneself from professional responsibility toward them as well. As the final act of the dramatised scenario of their life's story, they are singled out in institutionalised detention and nursing procedures, where they are finally lost from our perception, and with this robbed of their social identity as fellow citizens. Through this, public interest toward them is also dissolved except in one respect- the costs which they continue to require and which are to be reduced to the minimum. This often leads to measures which even put the clients vital existence in danger.

The attempt to restore human dignity in our practice with these people is the leitmotif of our work. The work of DCSCAT is, among other things, to take professional responsibility again in regard to those people who, through no fault of their own, have entered the life situation described briefly above. The social reality dominating for this group of persons takes the form of severe isolation, which is owed to their having been oriented toward the rigid norms necessary to the ability for adaptation, which was mostly already lacking in the person's early development and whose absence is interpreted as deviance and attributed to natural causes inherent in them. However, to attain that measure of adaptation which we as human beings all need in social community is withheld from them. The resulting isolation is appropriated into the person's identity and psychologically subjectivised in what is outwardly perceived by us as their so called problem behaviours. A further chore in the framework of DCSCAT is to minimise isolation as the central determining factor for "psychopathological" complexes, indeed, to overcome it to a great extent in the context of their de-hospitalisation and integration.

The situation of the concerned individual, even if it exists over a long period of time, is to be understood as a "crisis" (Dross 2001, Aguilera 1998) and generally requires a „crisis intervention" at the beginning of the work in order to establish a minimum of co-operative relations through which the chance of generating new ways of behaving comes about. Even this very difficult phase of getting started in the work - for the concerned individuals this means a changeover into extensively new life circumstances - should be realised under conditions that are as non-restrictive as possible. Restrictive conditions or measures are sometimes unavoidable, but even when they are necessary, for example in limiting violent attacks against others or destructive actions, they are of a much different quality than those which the individual has experienced up to this point. They do not serve to force - and this distinguishes them from paternalistic structures among others - the concerned individuals' adaptation and submission in order to preserve the peace and quite of the employees and to keep the institution functioning with as few disturbances as possible. Rather, they are oriented toward certain very basic rules in social interaction which are tied to maintaining the dignity of every member working in the team. The goal here is to be able to create a dialogue to overcome isolation in the field of co-operative processes which is centred around communication and interaction, around education, around emancipation and self-determination. Therefore, the restrictive interventions unavoidable in some

situations are not oriented toward a limitation of the life and learning fields, but rather, toward their opening up, as we, for example, also intervene in self-destructive or aggressive actions by stepping in and steering their effects toward ourselves without interpreting these actions as attacks. Through this as well, we open up new domains of actions tied to relativising the experience of only being able to gain subjective stability and inner security through such ways of acting.

Responsibility is and should be given over to clients depending on the individuals' developmental level and the assumed degree of self-consciousness they have toward their actions. This is also connected to a fundamental understanding which is described today in the educational sciences as *„education for everyone in the medium of the universal"*, as a „compound of three fundamental abilities that are self-acquired and for which personal responsibility is taken", which are described by KLAFKI (1991) as „the ability of self-determination", „the ability to determine together with others" and as „the ability for solidarity" (S.52/53). Work with this group of persons should not fall short of this understanding of education, otherwise the concerned persons are again excluded while, seemingly and falsely, one tries to tune in on them and their individual situation. This understanding of education characterises the content end of the work.

Here one must avoid idealising any facts**.** Rather, it is important to see DCSCAT's work to be the creating of conditions based out of the biographical realities of the concerned individuals which, step by step, reduce their dehumanisation and minimise the restriction and isolation. Often these new conditions have been successful in overcoming the latter completely. With this basis, common products can then be continually and constructively worked on together in co-operative processes and this means that also daily life can be dealt with. This is, and it is especially important to emphasise, not only the product but also the process which achieves it. In all of my work in this field, I have experienced at all levels that integration can only be achieved when process and product are identical to the greatest possible extent. All other methods reproduce inequality and exclusion. The working model of DCSCAT is at all levels identifying in this respect: in „crisis intervention", which serves to unfold a new dialogue when previous dialogue has broken down, in the developmental phase whereby a new „life perspective" is to be realised, which is characterised as „therapy" and - on this basis - in the phase of stabilising a new „life plan", which as „pedagogy" is to act as an accompaniment into the new life context.

In summarising this introductory orientation, I would like to refer to LEONT'EV (2000), who wrote about logical and mechanical memory in his early writings and studies: „We have repeatedly emphasised that central factor underlying the development of higher behavioural forms. *This factor is the social environment. The development of higher behaviour is a socio-genetic development. The regularities that we have inferred are not regularities of biological but of historical development.* " (p. 267, translated).

2. The „Peaceful" Normality of Dehumanisation

The pedagogical-therapeutic concepts, which are practised with the intention of overcoming crises in the group of persons described above and of allowing for development inducing learning are generally characterised by – as our clients' biographies show:

- the concerned person being herself the object of intervention or therapy
- whose goal setting is, upon close examination, directed toward the compensation for, but mostly toward the correction and finally only toward the control of the „challenging" behaviour, and thereby is built on
- the supposed disorder, deviance or disability of the concerned individual.

These practises are:

- bereft of content and thereby not educating - especially when the individual's problems are

aggressive or destructive actions or the assumption is made, based on a limited estimation of the cognitive possibilities available to the individual, that everything is too challenging for her.
- Thereby the world in which the individual is to live remains extremely reduced of objects, deprived of inspiration, and above all, bereft of real social communication and social interaction.

These practises originate in a „deficit hypothesis" made concerning these individuals, which even still today, with all of the positively noticeable aspects of a slowly emerging rethinking, remains owed to the view

- that it is the identified disability that brings forth a condition which can no longer be treated,
- whereby this disability and its manifestation are naturalised, that is, seen as owed to the „nature" of the concerned individual, conceived as her inner „essence", which allows the apprehended treatment measures to appear adequate as „specific to the disability" and to the specific needs of the concerned individual. Even measures of violence of a torturous degree are, from this background, identified as „therapy"[3]. But also forms of forced holding, of isolation in rooms, and the administration of high doses of medication can be named here.
- In relation to practically all of the people we have worked with, the view has dominated that they were seriously mentally disabled, and therefore that their learning possibilities, cognitive potentials and emotional differentiation in relation to experience were so limited that offering content-related activities would be of no avail and that the life situation offered to them would satisfy their needs.

In not a single case have the assumptions concerning the degree of mental disability and emotional differentiation proven accurate. On the one hand, this points to the inappropriateness of the term „mental disability" as an accepted category of the field in general and on the other hand to its misuse as a legitimising category for inhumane life conditions, which are actively created for these persons in special institutions. Such kinds of diagnostic „safeguarding" function as instruments in externally veiling and in internally explaining the lack of appropriate action possibilities at the professional level. The resulting problems, which are perceived exclusively in the disabled person, are understood as causes of those self same problems, which consequently can be located as residing in the person herself. „That's just what he/she is like", as I have often been told, and „that's why he/she needs this" is the conclusion.

The professionality of the employees is seen as grounded in enduring the concerned individuals' life realities as well as in the ability to let them be as they are, which also means to say that their needs are satisfied. I emphasise that this is the common view in relation to practically all of our clientele, expressed with a hand held up and, when allowed to speak „openly" and sometimes more or less veiled in the subordinate clauses of noble statements. Even the drawing of the kind of distinction that sees actions as indeed brought forth by the concerned individual, but not as arising out of her alone is not achieved. In „suffering" the situation, which is in general experienced to be insufferable itself, the „charisma", that surrounds their own activity also reaches its fulfilment. According to my experience, the „tolerance" shown and the apparent „understanding" of the concerned individuals are misused to legitimise, through mistaken diagnoses, the life conditions produced. They also serve to unburden the staff (councillors) in their daily work. A short report clarifies this:

A young man with his hands tied to his back stands bent over forward in front of a doctor's couch resting his stomach, chest and face on it in a subservient manner. A councillor undoes his hands from his back and brings them forward to his stomach. This procedure is accompanied

3 See for example the discussion about „forced holding" in the journal „Behindertenpädagogik" 27(1988)2

by serious self-injuring blows under his chin and to his face. The only object of communication is the tying of the young man's hands. Each person confirms with the other that it is important to carry through with the tying. The procedure itself seems difficult and awkward and is often corrected. The young man makes use of every opportunity to injure himself and remains successful. Upon the completion of the tying - only now after he has been rendered incapable of movement - does the councillor greet the man. They shake hands (as well as this is possible with the man's tied hands), make sure for the umpteenth time whether and that things are good like this; this is confirmed by both sides. Only with this does the councillor show the remotest feeling of joy and a look of relief comes across his face.

I would like to stress that this problem situation is not to be explained and overcome by shaking a finger at the councillor. Most councillors, trained at the lowest rung of remedial education qualification levels and prevented in their professional life from adequate in-service and advanced training offers, are extremely exploited - this relates to the tendency of institutions to preserve themselves as they are, which is not to be underestimated. There is, however, also very frequently a marked ignorance in the instructors and trainees about how to attain the knowledge and research findings to these questions which currently exist in the human sciences, so that also in this way a change in their own thinking and action remains obstructed. That we are asked for consultation and intervention is not always owed to an insight into the problems. This is especially clear in the process of „integration" of the clients into new life contexts following the crisis interventions and therapy, which in spite of very extensive positive changes in almost all cases, is made considerably more difficult or is forced down to a level which is lower than possible for the clients. In relation to this, I have often had the conservative-traditionalist impression of: „It cant be, because I will not have it."

Without attaining a „truth in the situation", as MERLEAU-PONTY (1960) formulates it, we remain in the »treatment« of people, through all of the apparent proximity, at a great distance to them. He writes: „As long as I, with the ideal of an absolute observer, hold tight to a piece of knowledge without a standpoint, I can in my situation only see a source of errors" (p. 136/137).

3. Aspects of Fundamental System-Theoretical and Psychological Questions

In the long history of DCSCAT's development[4], three motifs have been dominant. In shortened form, they can be understood in the mirror of my own working history

1. as the proof of the learning abilities and potential for education of people living in extreme and most serious life conditions at both individual and social levels.
2. as the realisation of the theoretical and practical conceptions which I have developed of an „integration" into »general education«, in the sense of common education and lessons for disabled and non-disabled children and pupils, without exclusion based on the kind and degree of disability and
3. as a refutation of the view of those philosophies and philosophers supportive of „Euthanasia" which and who assume that seriously impaired people do not exist in time, do not have a future-directed consciousness, a desire for a future life, and a faculty of sensation, as well as being devoid of the ability for sensible relationships. Hence they are, in this thinking, no distinct entity[5], no person, which has consequently, in relation to this group of persons, led to a new debate about the value of life and to the desire for a „new euthanasia", which quickly

4 The first beginnings of this working method took place in my work at the MARTIN-BUBER-Schule in Gießen. DCSCAT gained the form presented here in the second half of the 1980s in work at the University of Bremen.

5 According to Duden (Vol 5, 1982, 4th edition, p. 193 and 219) „distinkte Entität" („distinctive entity") means a clear and perceptible (separate) existence as opposed to the nature of a thing.

has gained and is gaining an ideological foundation in the current of a Zeitgeist's valuing of human beings according to cost benefit analysis, of globalisation and deregulation in the distorted picture of an egocentric self-realisation mania. (Daub/Wunder 1994, Christoph 1990, Feuser 1997, Jantzen 1991, Singer 1984, Stein 1992, Wolfensberger 1991).

In an important meeting between FRANCO BASAGLIA (1980) and JEAN PAUL SARTRE, SARTRE emphasised: „It all hinges on practice - it is the Achilles' heel of ideology" (p. 40) – those ideologies that, among other things, hold our views about human development and human learning to an almost pre-scientific state with the background of an antiquated world view, ideologies which aim at the educational impoverishment and the psycho-social and physical extermination of the people we work with pedagogically and therapeutically in the framework of DCSCAT.

Our concern was not, then, primarily the development of a „therapy", but rather a realisation of theory-accompanied, practical access to extremely excluded, isolated and in many ways oppressed people, which we in time systematised. This was approached with the goal of overcoming such life conditions and, where they threaten to come about, to be able to treat them preventatively. In the didactical transformation of this experience into theory, the proof was successful in terms of the three aforementioned aspects - also in relation to people with the most different of syndromes, which qualifies this working method as a basis therapy.

The primary focus is on those »relations between behaviours«, which enable, in terms of co-operation fields, development-inducing learning which again results in new possibilities of action. DCSCAT organises these co-operation relations in such a way that they are perceivable to the clients and that the common objectives are personally attainable by achieving sense-creating meanings in the biographical context. In principle, DCSCAT can be practised in any place, but the focus is never to correct behaviours so that the concerned individual can eke out an isolated existence in all places and under all conditions, with the least possible trouble for her councillors and with the smallest possible financial burden.

Contrary to the traditional orientation centred in the humanities, we are able to create a picture of life and the evolution of living things, included in which is the development of an individual, on the basis of natural sciences which have again opened themselves more strongly to epistemological philosophy, for example, this can be seen brought together in the so-called self-organisation theory and in some of constructivism's own basic assumptions. This makes clear that even very seriously impaired people - even in the state of deep coma - cannot be denied to have the fundamental psycho-social characteristics that we recognise as typologically human.

An according fundamental consideration shows that each living system can only be understood as open to its environment, which in this way is oriented toward its environment and which itself changes in every cycle of exchange with the environment. This referenciality to the world involves an individual system conjoining with the world and with itself, which is why it - in spite of permanent change processes - is able on the one hand to remain identical with itself and on the other to reconstruct (with the system's means) the exchange processes. This means it accumulates knowledge about the world in the relation of itself to it. Such systems are, in relation to their characteristics, considered to be dissipative and autopoietic (Maturana 1985, Maturana/Varela 1990).

The first signs of system characteristics, which we indicate on the human level as ego and self-consciousness, exist even in pre-biotic structures. They can not be ruled out even by the most serious of impairments. With this, „time" is the proto-organiser of a living system: it organises the organisation, brings about the construction of the internal structure and therefore is a central component of our work, which expresses itself in the total range from pacing procedures to intonative language-modulation to rhythmical-musical activities. With „pacing", intended is not some sort of tempo-making in the sense of quickening activity, but rather time-making in the sense

of making actions (both motor and linguistic) rhythmical. This rhythmicalisation is done in accordance with the basic rhythm of the person we are working with, which allows the concentration and attention spans available to the person to be widened and made full use of. Here, in terms of neuronal synchronisations, the point is to generate an inner timing on the basis of (external) guidance (external linguistic and motor synchronisation of the instructor or therapist in the function especially of P1 - but also P2, P3 and client - see the diagram at the end of the article). This inner timing then allows the client to, on the one hand, maintain the constructed orientation (or orientation activity) in a stable manner, and simultaneously on the other hand to filter (or fade) disturbing influences out of the perception field.

Moving on to a very few factors from the psychological side of our basic position: in terms of system theory, we recognise two realities of the human being: that of her exchange with the world and that of the inner construction of »her world«. This indicates a relation between *external functional* and *internal structural* contexts, which we can also describe in pedagogical and psychological terms as the relation between *learning* and *development*. Within these relations, the subject is oriented towards such events or happenings which create for her *»subjective sense«* through the satisfaction of her fundamental needs, and which therefore have a 'useful end effect' (Anochin) for self-preservation. This takes place through her actively striven for activity which-steered by her central nervous system - is realised in her perception, thinking and acting - that is, by means of the psychological apparatus. This is, in summarising the latest research conclusions provided here, which I unfortunately for reasons of time cannot refer to, the human being in her fully particular and irreplaceable existence. This is, to mention only one example, already expressed in the smile reaction of infants upon seeing the eye-forehead part of a person - be it only a mask - as RENÉ SPITZ empirically studied already 50 years ago - and it is expressed in the fact that serious developmental disorders occurred, indeed in 37% of the cases he observed death was the consequence, when inter-human relationships, in terms of their quality and quantity were inadequate or missing entirely (1973, p. 114).

Inter-human dialogue is *the* important „Attractor"[6] of human development, which can be found in the form of „inborn trigger mechanisms"[7] all the way down to the level of the genetically co-ordinated memory of a species. That which a human being primarily needs and what satisfies her fundamental expectations and needs is not something she needs to learn: it is the human being! In the psychological sense, these relations in the social domain – in the sense of its internal construction - as a super-structure can be understood as „I", which allows for the perception of other persons as an „I" like me, and to identify and represent them as something that is not „I" but „you" – a limited entity.

Looking backward in time, we can grasp the dialogue-centred co-operative context of two or more entities as a phase space exceeding the individual domain, in which the common and intra-individual space, can be triggered in a synchronised way through guidance and the „de-railed" dialogue (as Spitz called it) can get back on track. This is possible already through the induction of a common rhythmical action, in which for example early stereotypical base patterns of the clients can be taken up again. In this way, internal time can be generated and neuronal as well

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6 Those attractors can be called operators which give the constrction of the system's internal structure a „certain direction", for example, that the development takes ist course in the direction of a personality structure that we perceive and classify as mental disability or as autism.

7 The »angeborene Auslösemechanismus (AAM)«, here „inborn trigger mechanism" (ITM), is a „receptive analyser system. Ist ability to process information consists om a filtering out of behaviour-relevant features and their arrangement in an inborn scheam of these features' configuration. The ITM unlocks a stimulus-related behavour upon the consensus of the filtered and typified entry information with the information manifest in neuronal receptor wiring which is handed down by the memory of the species" (Sinz 1976, pg 40).

as psychical structures can be activated and stabilised. The apprehension of contexts relevant to biography, as, so to speak, external happenings, „force the way" to internal (nervous system related) changes of state which allow remembering and/or generating new information, which means creating new knowledge, new experiences and saving them in the most various forms of memory. Hereby the contexts mentioned can in the process of apprehending be made transparent (and thereby perceivable), also when they are of a high complexity. Creating memory - as the central factor and basis of learning - should be initiated in a differentiated way. This is accomplished by addressing different memory and thereby learning centres in a structured way through the content of the different activities that we carry out with the client - this in terms of priming, of the knowledge system, of the procedural acts and the episodic-autobiographical memory, which enables the recognition of situations already experienced, remembering facts, generating actions and movements again and indeed remembering one's individual life story.

In relation to an understanding of development we should conclude: *development* is primarily dependent on the degree of complexity of the respective other, whereas the means and abilities of the individual system always come in second place and when understanding a human being, what can become of him/her (according the previously mentioned contexts) and according to his/her possibilities is primary, whereas what and how he/she is at the moment come once again in second place. Here it is not meant that one is to think of the human being in her present existence only as the not yet possible - quite the opposite: a human being is to her present state what is momentarily possible in respect to the possible changes; that is, competent, no matter how disabled she may appear to us. In other words, one can state, with MARTIN BUBER (1965): **„The human being through „You" becomes „I"** (p. 32) Inverting this leads, though, to the knowledge that I add here: ***She becomes the „I" whose „You" we are to her!***

The two addressed realities show themselves on the one hand in the external reality we are in a constant exchange with and on the other hand in an internal reality in terms of the reproductive reconstruction of the world that is experienced externally; this indeed with the means individual to the system which are available to each person both individually and through her socialisation and enculturation. The changes of inner structures and the psychological functions which become possible through them (in perception, thinking and acting) come about through the conjunction with external happenings; a subject's own active activity, which can be substituted, but cannot be carried out for her or be replaced. In such a way arise both the behaviours labelled „pathological" by us and those labelled „normal", which in any case are to be understood in terms of „developmental logic". The evaluation as »pathological« and/or »normal« is purely of a social-normative kind and without epistemological subjective-biographical value for the genesis of human development. Of significance for this are two contexts to be understood as mediated dialectically, namely that of „sense" and „meaning" and that of „bonding" and „relationship". These are two constituting factors of our work, which, if we may get ahead of ourselves, are represented in the so-called setting of DCSCAT.

That which is - I repeat – experienced in the aforementioned contexts as subjective creation of sense, which means that it has a „useful end effect" for the system and therefore is liveable in the form of positive emotions, this is allocated *„meaning"* by the subject. The *„relationship"* to these events and objects itself gains the quality of a *„bonding"* out of which freedom from fear, security, trust, and self assurance result. On the basis of a subject-securing „bonding", (once again a dialogue-centred, co-operative domain in which the vital physical and psychological needs and motivational constellations are extensively satisfied), new co-operative relationships and new meanings can again then be formed and established. This means that the human being is able to behave in respect to her world in an active, curious and discovery-seeking manner. Without being able to take up this subject any further here, please refer to the supplementary theory of bonding

as was founded by JOHN BOWLBY (1957, 1976, 1987) and further developed up to today (Spangler/Zimmerman 1999, Endres/Hauser 2000).

Arising from this background as well are the possibility and the willingness to open oneself to the *„cultural meanings" of events and objects*, on the basis of subjective sense which is allocated to these events and objects in terms of meaning, and to acquire them in a lifelong learning process. When the human being through this changes her possibilities of perception, thinking and acting in terms of increasing complexity and diversity, then we would say that she develops. Education and therapy are realised in the dialectics of individual, subjective and personal sense construction processes and cultural meanings. Or in other words: *A human being gains access to things through human beings and accesses human beings by way of things.* It becomes clear what a conception of a basis therapy is to achieve when taking into account the sketched out systemic and psychology-based considerations of the relation of the human being to her world and to herself.

Many of the people we work with have not only developed ritualistic-stereotypical, self-injuring, aggressive and destructive behaviours in the course of their life. They have also had to - and this in a few cases repeatedly - go through the experience of their vegetative functions collapsing with near fatal consequences. They have been through many treatment attempts with the most various kinds of procedures, a very few also internationally with famous experts, and others have experienced the same measures for more than a decade and a half despite all lack of success. The failed pedagogical-therapeutic efforts and - with an increasing worsening of the situation - the application of contra-indicative measures led in many cases to a complete psychological collapse. Also, under the internal and external conditions of a high degree of isolation, the few relationships the clients had collapsed, ones which were often from early childhood onward very delicate and which never allowed for truly stable bonding. Detained in a setting void of culture, treated with punishing measures which were often not recognised as such, they remained entirely shut inside themselves. Without the possibility of co-operation, their activities became divorced from dialogue and were dissolved of their species-specific reference. Actions like stereotypies, self-injury, extensive rituals and others gained an auto-compensatory, counter-regulatory and thereby existence-securing quality under these conditions.

Structurally, a deep-reaching developmental disorder with psychotic dimensions resulted, and functionally, the attempt to activate the most elementary functions of biological sense construction with the means of the individual system (for example through rhythmic rocking, striking and screaming): by striking her own body, which becomes the object of the action, and through muscle movement, a person attempts to stimulate herself in a diversified sensory and proprioceptive way, and to trigger off the central nervous system through the rhythmical nature of this action. This is to enable a minimum of information to be provided in a world of complete isolation and also enable a minimum of inner consistency - this also means of coherency of the world - in order to co-ordinate vital life processes and to be able to create a minimum of psychological experience that is still bearable.

Seen systemically, the kind and degree of a disability, as well as what appears to us to be their symptoms, are the expression of the integration of border conditions of a system into that system with the means of that system. Therefore, the disability follows »developmental logicy« and is not »pathological«. It explains its function in terms of the concerned individual's competence in realising her life processes under the given conditions (whether we are talking here of the case of a coma, an Apallic syndrome or autism). And if, as is often experienced, the auto-compensatory and counter-regulatory actions are themselves of such a kind that they shorten or destroy the life that they enable under the given conditions - this is no contradiction! Life itself is an expression of the will to live, as ALBERT SCHEITZER showed in his works on culture and ethics. The simple

statement "I am life that wants to live, surrounded by life that wants to live" casts light on this situation, also in its ethical dimensions.

4. „Dialogue-Centred, Substitutive, Co-operative Action Therapy (DCSCAT)"

It ought to have become clear that in making a model for people with whom co-operation, and, part and parcel to this, dialogue seems no longer possible or has been given up on, it is precisely these elements and the according systemic and psychology based answers which are to be achieved, and which must be seen as fundamental for the realisation of human life. RENÉ SPITZ (1976) summarises this in a simple statement similar to that of BUBER: *„Life in our sense of it is created through dialogue"* (p. 26). This can - to bring together important elements once more - only be realised in co-operative contexts, which can in turn only be created when we work together on an object or subject matter in anticipation of knowledge to be won or of a common product to be created. This can and must very often be oriented toward dealing with activities of everyday life, although it represents human culture in the way in which it is realised - and enables education. Through it, the clients are not the object of our activity, but actively acting subjects in common co-operation! Therefore the focus is not, as it is in common therapies, on treating the behaviours of the concerned individuals, but on the structuring and design of an extra-individual field of space and time in which the clients can learn to carry on a dialogue with the aid of their current perception, thinking and acting possibilities, no matter how reduced these possibilities seem to be. This means learning to achieve the next highest level of development. Through the reduction and finally overcoming of isolation, the concerned individuals no longer need to display compensatory behaviours which, except for providing protection from them, are not directly addressed in therapy.

The setting of DCSCAT (elucidated in the model diagram), takes the systematic and psychological elements into account in that generally three persons (P1, P2 and P3) co-operate and interact with a client:

1. One person (**P2**) represents the EGO of the client and **substitutes** - as we could say, for example, in the case of severe autism - the psychological functions which have not been brought about through the „you" or all those that have been obstructed or have not yet unfolded, so that the fundamental needs of the client can be satisfied, such as that for freedom from fear, for safety and security, and for stable dependability of a partner in a relationship. In this way, Person 2, who usually works behind the client, guarantees her, for example, protection from having to inflict self injury and also facilitates the experience that one's own psychological structure can remain maintained through a highly synchronised shared activity and without auto-compensatory actions. Through such a relationship, one that is experienced subjectively through the senses, the quality of bonding can be achieved, on whose basis a new »life perspective« can be brought about and, included in this, an extended personal creation of sense and allocation of meaning which is directed toward fellow human beings and the world (represented by P1).
2. Another person (**P1**), who generally acts vis-à-vis with the client, can now for her part work on the demands arising out of dealing with daily situations on the highest possible cultural level. This takes place through dialogue and communication as is known from out of pedagogical processes. During this time, the dialogue led by P2 in co-operation with the client secures her at the most fundamental level. In this way, parallel to gaining a new »life perspective« (with P2) a new »life plan« can be constructed, and the client can step by step become capable of realising these two as autonomously and self-determinedly as possible. The meaning of actively experienced contexts, which correspond to our culture (co-operation

P1-client) is mediated at the same time and in the context of new sense creating processes (co-operation of P2 with client).

3. A third person (**P3**) plays an assisting role and/or helps to structure the learning field and/or acts as a model in the make-up of the client, P1 and P2's action. Her task is to, through structural help in the field of action, eliminate those obstacles which, despite careful planning of the co-operation, could threaten to impede upon the client's actions or cause them to fail. The „model"-function consists in P3's demonstrating as a model, in the framework of co-operation between P1 and client, all those demands directed toward the client. This is carried out very clearly through movement, gesture, mimic and performance. According to our experience, this is a very significant orientation aid for the client. With increasing complexity of the client's own relationship network which is now to be worked on, P3 can be included in the interaction and communication, while she does not herself get involved - unless it has been planned or arranged beforehand - in the co-operation between P1 and the client or that between P2 and the client. If the two main functions taken on by this person are not needed, then P3 represents from the beginning the 'normalisation' of the interaction network to be striven for in the field of action.

This P1, P2 and P3 model portrays the basis-setting that can and must be expanded functionally and therefore also in terms of personnel, especially when we must decide to work with inpatients, as is true about 10% of the cases. In cases where the stabilisation has been successful, P3 can eventually be removed from the setting first. In many cases the goal of working on a 1:1 basis could be achieved, whereby it is recommendable according to experience to take the P2 function and position on again to a considerable extent in crisis situations.

All three persons orient the structure of their own actions, which means the carrying on of dialogue, the presentation of tasks, the verbalisation of each working sequence among many others, toward very precise regularities founded in the psychology of learning, just as it is obviously also indispensable to have a stable time-space structuring of the course of work and a corresponding systematic curricular-didactic preparation of the content. This is done according to the duration of the therapy which also, when the situation arises, can and must follow in a 24 hour cycle. Unfortunately, this context as well cannot be adequately handled here, but please note that above all, the sequencing of micro-sequences relevant to learning psychology carries a central significance in communication and interaction. Some of these are (1) the facilitation of adequate vigilance (neurological awakeness/orientation), (2) the giving of simple, clear, and unambiguous instructions through clear gestures and signs accompanied by vocal intonation, (3) the guaranteeing of help, esp. of medium strength (for ex. cues) and (4) giving positive feedback upon completion of the task. The impression of purely behavioural therapeutic procedures, which one might get from looking at the interaction and communication processes in the setting from a phenomenological point of view, is fundamentally wrong and reductionistic with regard to the conceptualisation of DCSCAT. Also, punishing measures like „time-out" are not undertaken as they are in behavioural-therapeutic settings, because in our work the client is never disengaged from dialogue. For example, after a collapse of co-operation between P1 and the client, P1 remains still during this time, as if „frozen" (I will come back to this once more later on) and P2 carries on the dialogue in order to stabilise the client: this is no means of punishment. The dialogue - usually not observable and practically not to be documented on film - is always carried on by P2 parallel to that of P1 through body contact and many other actions, as well as verbally (usually only in whispers) and is directly begun at the latest after the dialogue with P1 has become no longer possible.

The work with inpatients is organised in a 24 hour cycle and limited to a maximum of four weeks is as a totality highly structured in all its elements: a stable time-space structuring, a

preliminary orientation toward the persons working with the clients in the setting, and a corresponding systematic curricular-didactic preparation of the content are indispensable. The course of the day's work and its timed structuring are, as far as possible, anticipations of the time after therapy, of the fields of life and activity in which integration is to follow. Four weeks are sufficient to tell whether communication will be achieved and the set goals will be reached. Generally, the clients we are speaking predominantly of here could be integrated into their new fields of life after 19 to 22 days. If, in this time period, we were not able to conclude that the first signs of a clear bettering of the clients' situations were present and that development processes were underway, we would assume that our analysis of their life situation and present state was incorrect and therefore that our content and relationship offers were inadequate. It would then have to be planned anew. With this exception of one case (see Feuser 2001), this has not as yet been required. This case, which has become known through the ARD documentary, states an exception in various elements but cannot be handled here. I would like to refer you to the journal „Behindertenpädagogik", volume 2/2001.

It is especially important to mention the significance of the relation between P2 and the client. Although a high and low priority in the sense of a hierarchical structuring cannot exist in a co-operative action oriented toward education in a collective, the relation P2-client in the work represents the leading figure in the truest sense of the term. P2 substitutes the client's ego in the sense of the perspective of what can be achieved according to the client's possibilities, but which the client cannot realise with her own strength because of the momentary situation. In this way the content-related side of the work aims, in the sense of the „Zone of the next Development" (Vygotskij), at the highest level, while the relationship securing takes place on a very fundamental level. With this latter, the attempt is made to stabilise the emotional situation, whereby the affect-generating actions arising from the background of many traumatising experiences, which are themselves not seldom the consequences and expression of paroxysmal attacks of fear, slowly begin to lose their right of way. This is only possible in the context of the attractor of the change, which appears in the client-P1 relation, of the client's own situation, both in respect to gaining a high degree of compentencies, and in terms of gaining a higher degree of self-determination, possible through precisely these competencies. The guaranteeing of protection and security and the anticipation of the productive and cultural needs of the client, both of which appear in the relations shown, are the two sides of one and the same coin. In this set-up, the leading figure - to come back to this - is the client and with her P2. The processes of sense creation are generated on the side of emotional experience; this is to be substituted and thereby stabilised to such an extent that the exchange and learning processes explained earlier can begin to take place, even if only for short time periods and with few sequences at first.

Simply because of the fact that the daily situations to be dealt with, which range from activities related to the clients' own bodies like getting dressed and taking meals all the way to the construction of their own possessions and the setting up of their own private rooms, are organised according to an appropriate cultural level, the related activities can become once again enriching. They offer a kind of framework, are requirements for the production (1) in the area of communication: of a common culture going beyond the activities, (2) of the structured expression with various media and goals, (3) of the acquiring of cultural techniques**,** in the proper sense, with the help of contents that are both oriented toward needs and related to motives. This is work, always to be realised in co-operative relations, which, above and beyond all age levels, enables and equips both in terms of the technical and the social aspects, like learning in schools, production work, and organising one's (leisure) time. From the very beginning, the expansion of the common fields of action into regular fields of life is striven toward, and the client is prepared for the therapy's bridging over into future life contexts.

Arising from the structure of the dynamic processes between client, P1 and P2 are the possibilities for stress-free actions, even when, at the beginning of the work, moments for them are short and seldom and the dialogue collapses again. Here P3 gains a particular significance which, like P2, is not available in classical therapeutic settings. As a model, P3 gives an enduring, stable orientation in connection to the work and situations that are to be dealt with, without letting herself be influenced and impressed by the fluctuation between a stable dialogue's creation and its collapse which, at the beginning, appears in high frequency and cyclical. In reference to P1, P3 represents an analogous model of the actions that are necessary in the situation and of the resulting product striven for. In this way, through P3's functions as well, dependability is able to enter the scene of events in spite of the crisis.

In all this, a foundation for the clients' ability to act is the clear and easily comprehensible arrangement of all working objects and tools which daily follows in the same way. The arrangement and design of the tools and materials is customised to the possibilities available to the clients and altered according to their development. Many people and hands work together without disturbing each other, each performing its own function. The product made in co-operation is treated in accordance with the material used and the kind of product that it is. It is highly valued, which symbolically elucidates the way in which we value the clients. In this way, step by step and often in micro-sequences, confidence unfolds in the clients' own ability ... and out of this, self-confidence. Living in institutions, clients are generally deprived of personal possessions. These possessions can be built anew, given over to the clients' hands and thereby competence and the courage to be responsible for something – eventually for oneself - can be initiated.

P2, this is especially important to stress, *enables* the client to act. Even if the client were to handle the communication between her and P1 „incorrectly", P2 is not to prevent this action or limit it. Avoiding mistakes is the task of P1, that is, through help and correction, to provide the client again with new task-oriented action possibilities (with completely new activities there is also, obviously, help from P2). P2 limits the action, for example, through the protection from self-injury that she guarantees a client. When the client's actions are aggressive or destructive, the situation in which dialogue and co-operation collapsed is left. This is to re-stabilise the client in a „more neutral" place and to direct away from heavy damage to others and objects. After the client has been stabilised through the help of P2, the situation can be returned to, where the shared action with P1 can be taken up again at that place in the process where it was interrupted; depending to the situation, the beginning of the action sequence can be gone back to. With this, the principle is once again to be upheld that P1 does not now depict the problem (this was taken up in the framework of the client's stabilisation through P2), but rather continues on in a calm manner and supports the client with strengthened help after the crisis. If something has been damaged in the crisis, it is replaced and the previous situation recreated through P3 in her function of structuring the learning-field. Accordingly, P3 in her model function continues on with the tasks to be carried out in such situations as well, performing the activity in the way necessary and also in the way that the client should have performed it. This points to the necessity of a work-sharing perception of P3's function - just as two P2s can be brought in, but only one of them can take over the tasks related to this function and carry on the dialogue. In cases of clients who are acting out in an especially serious manner, a further P1 can be brought in when P2 leaves a situation with the client after a crisis has occurred, in order in this way to, again in the P1-P2 model, allow for a more intense and quick overcoming of the crisis. After stabilisation, this P1 (we call her Crisis-P1) refers only by way of orientation and guaranteeing other help to the client's return to the real action setting, where she is received by the (regular) P1 with orientation toward the continuation of the work.

This clear separation according to function of the persons working in the team creates the

necessary transparency of very complex social and object-related situations as well, so that the client can perceive them adequately and above all interpret them accordingly, which means in relation to future cases that she can anticipate them as the course of action that in all probability will repeat itself. Psychological stability and self confidence in the sense of the dependability of one's own perception also result among other things from precisely the conclusion that the experiences the client has had prove accurate in terms of a new „model of future events" which develops within the clients' understanding. In our work with all clients we have been forced to conclude that there was hardly any adequate dependability in connection to the relationship partner in their previous history and especially in relation to their councillors in institutions. This holds true both in relation to a stable presence, that is, working times in the sense of the roster regulation, as well as in respect to the answering to and evaluation of the most different daily events in terms of the extent to which pedagogical-therapeutic principles were followed and whether (if at all) the councillors kept to the arrangements they had made among themselves.

Generally, the following is true: if an obstruction or collapse of the client's psychological stability occurs through the failure of dialogue between P1 and client, which are to be examined and which can result for example, from inappropriate demands or lacking timed synchronisation in the co-operation among many reasons, P2 then takes over and carries on the dialogue until the client is re-stabilised. In this phase, which can be overcome amazingly quickly, P1 remains still, as if „frozen" at that place in the time-space process where the „dialogue derailed" (Spitz), and only continues with the dialogue after the client has been stabilised, upon a cue from P2, and does so calm, relaxed, without commentary, as if nothing had happened. Restrictive-scolding, punishing-sanctioning behaviours on the side of P1 are contra-indicated.

In respect to its depth, the relation of P2 to the client can be partially described as „constructive symbiosis". That each relationship level requires special reflection, especially in the context of transfer and counter-transfer, should be clear considering the function of P2. The transfer processes are directed toward P2 in a special way, and thereby also the clients' aggressive-violent potential. This potential is to be assumed and taken up in this function, which doesn't mean surrendering oneself to it without protective measures, but means not repressively sanctioning the clients' violence. Forced holding and sedation are positively ruled out. According to the client's developmental state, her responsibility for her own actions is articulated and basic rules of a constructive social togetherness/communion are clearly pointed out; their keeping is demanded. Most simply said: P2 is not a control person who is to ensure that everything runs smoothly and without problems, that things are easier for the other co-operation partners, or that they can remove themselves entirely from responsibility for what is happening.

In work with aggressively or destructively acting clients or also those who need to be protected from serious, compulsive self injury, we are also, in the sense of the aforementioned necessary limitations, in a position of exercising power as we try to leave the violent field and acquire a space for stabilisation. Power is also involved, in order to lead to working contexts or into situations that are massively warded off, even though we are able to assume, on the basis of research and analysis, that contexts of meaning which are relevant to the clients' needs and possessed of adequate motivations will probably be created. This is to be seen especially against the background of the clients' long history, in which they have tried with the means of extreme acting out and self-injurious action (often the only elements of their life situations that were communicatively perceived) to refuse work, situations or demands. On the side of the councillors, these behaviours are often interpreted as indisposition on the part of the concerned individual, whereupon they withdraw, allowing the disabled persons some space which, on the basis of such interpretations of the individual's state, is seemingly needed. Such examples are, however, much more a shrinking back from responsibility toward these persons which, as I often have to experience, are rationalised

as a pedagogical or therapeutic style which supposedly serves the autonomy and self-determination of the concerned individuals as well as the empowerment movement in a special way. Thereby the brutal rule in connection to this, founded in the supposed non-exercising of power, is not recognised.

I would like to clarify this with an example arising from work with a young man who was severely autistic from early childhood onward, and who, during the three years before he came to us here in Bremen, was highly isolated and had hardly been included in social interaction anymore because of extremely aggressive and destructive behaviours.

When the young man acted out, he could hardly be controlled by three adults. When he was „locked away", the only thing available to him other than his clothes, his diapers, a soft-ball and a mattress were some newspapers, which he tore up. We came quite unambiguously to the conclusion that he must, through this action, have some concept of „letters", however they were represented with him, since the diagnosis of a mental handicap so severe that no learning or educational abilities were present (no educational measure, so it was reported, had ever led to a positive change in him), did not appear maintainable. It also seemed that there must be some other means of communicative expression that could be developed with him through which messages could be got across in another way. All of the factors led to the conclusion that the best thing to do would be to make him an offer of learning written language. We decided on letter stamps and to begin the work with the sentence: „My name is NN". He warded off every working offer and could only be brought into co-operation by way of playing music together. As this was established as the „setting", we began with the writing work. Six people were required in order to get him to the prepared and structured working area next to those working areas of P3, to take with him the stamp in his hand, press it against the inkpad and to stamp out - letter for letter - the entire sentence. After just a few working units, he strove toward the work, and on the 21st day, he was sitting in front of a computer which was speaking for him by way of a speaking program. He had his journal next to him, pointed to a polaroid photo, typed the photo heading „I'm dancing" into the computer, got the computer to pronounce this for him, pointed again to the photo in which he could be seen dancing with a group of students, and pointed to himself!
These days I receive a letter from him now and then – stamped (!) because in the second institution, the one he has lived in since the therapy, he is not valued enough to make a computer available to him and to further the work with him in written language. One of his letters read: "Mr XY is hits me".

The total biography-oriented research show no reason why this young man himself, through any other offers or measures and in a foreseeable time period, would commence work of the kind we did with him. We used power (meaning force) in order to find a way to begin the work. Seen from the periphery, this is judged as „violence" - and many institution employees make this judgement (but not, however, in regard to those measures sufficiently mentioned here of mechanical and medicinal prostration and isolation by way of locking up, as is common with regard to this group of persons). Our action, presented above as an example, is fundamentally distinguished from the power structures that the concerned individuals have experienced in their life stories. The latter are measures of direct as well as structured violence (and misuse of power in the form of rule, secured by the institutions) in that they are of a restrictive and preventive nature, such that make learning and development impossible. This means the concerned individuals are limited in such a way in order that staff are exempt from the possibility of damage and are left their peace and quiet, that the lack of personnel is compensated for, and thereby that the institutional processes run with the least amount of disturbance possible, among many other reasons. In the case of the young man described, his „locking up" was justified by the argument that the personnel have a right to be left in peace and that he needed it because of his disability.

The limitations that we practise in applying force serve to open „domains of possibility" in which the concerned individual can learn new things so that development can begin to take place again, so that competencies of expressing oneself, making decisions, agreeing or disagreeing in a group among many can be gained. Generally, the focus is on bringing the client into situations which allow for co-operative action aimed at a shared product, something that is not achievable in just any arbitrary situation.

If we see cause for such a use of power, it is to take place only

- after intensive research, analysis, and determination of the subject matter, which takes place in open discourse with all those working in the team, and which includes the parents, the councillors and any others who have been or will be responsible for the client,
- in that kind of a professionally open manner that the entire course of events is observed, recorded, evaluated and once again submitted to evaluation in the framework of therapy-control,
- with concealed (one-way glass) participation of the aforementioned persons and
- with a time limit to the measures - according to a time period in which it seems possible to evaluate conclusively whether the measures have been successful or not.

It is in this way that we go about our work in what is certainly, ethically speaking, a very problematic area, one for which there are no rigid borderlines in the sense that they could not be hurt, as for example, how this is the case in the process of transfer and counter-transfer which should be continually reflected upon. The aforementioned control mechanisms do, however, provide guidelines which can preventatively and extensively minimise a misuse of power for the clients and for those who work with them (and work in front of the public eye of the others). These guidelines also provide for, should the situation arise, the immediate exposure of a misuse of power.

JANTZEN (1990), in the second volume of his „Allgemeine Binhindertenpädagogik" (General Special Education), deals with questions of general and special therapy for the patients and, working under aspects of therapy as a healing dialogue, highlights „the patient's discovery of the therapist for the production and maintenance of the patient's ability for dialogue" as a central element, one which is relevant in a particular way to the DCSCAT clientele, as should have become clear. According to JANTZEN, one of the three levels to be taken into consideration in this process is the „recognition of the autonomy of the patient and the realisation of her own action as an instrument in the sense of an expansion and regaining of her autonomy on the highest level" (p. 331). In order to be able to achieve this side of the therapy under seriously burdening conditions, „orientation principles" are necessary, as they are in securing the therapeutic actions in those situations in which the therapist sees no change and no success. These principles are „methodologically settled in on a level between law and norm". They are:

1. "radical partisanship for the client.
2. Democratisation of the therapeutic processes and demystification of the role of the therapist.
3. Absolute explicitness of the therapist's actions.
4. Positive solution to the question of power.
5. Construction of individual reality control in the sense of the patient's winning back of her own history with a simultaneous conquering of her action and life possibilities in the present.
6. The client's activity is to be understood as embedded in collective life processes and must be organised accordingly.
7. The search for an appropriate alliance partner for the therapist and client" (see p. 331-332).

Related to the clientele we work with in the framework of DCSCAT and to this action model, far reaching realisations of all of these orientation principles have resulted both in relation to our own therapeutic perception and action as well as for the concerned individuals, with whom

common domains of life could be acquired, such as the realisation of learning and development processes. The possibility of bringing about the latter had been kept from the clients through what was often years of brutal, although professionally veiled violence based on a dehumanising picture of the disabled and of human beings. Further exposition of these problems, however, cannot be gone into here.

Additionally, please take note that we - if possible - already decrease dosage of psychiatric drugs before working with inpatients or, during this work, decrease the dosage below the threshold of therapeutic effectiveness. We also, after few days or usually even when beginning work, no longer practise measures of forced holding during the day and cut back those of the night as soon as possible. The parents can participate – usually concealed – in all of the activities, although we do not train them as „co-therapists". They are parents and should remain so, finding their own way of living with their son or daughter. All of their questions are answered; they are given consultation and can participate in all of our consultation sessions.

The employees with P functions wear earphones which allow for one-way communication, and through which direct supervision is possible. This can take the form, for example, of help regarding the processes' timing, of help regarding the succession of the individual steps of the work as it is carried out, of orientation toward all that is to be taken into consideration, of commentary about the most subtle of nuances in the client's behaviour, or of instructions on how to act. These instructions are to be put into action in the situation. Questions about them which come up are dealt with in the regular evening team sessions at the latest. These sessions serve reflection on the day's happenings, the detailed planning of the content of the next day's work, the refinement of the diagnosis and the working method, the development of the therapeutic offer and the formation of teams for single sequences, to name just a few. The sessions usually begin upon handing the work over to the night-team and go on for about three hours. It is indispensable that all partakers in the process participate.

We plan on a good six months for the preparation of work with inpatients, and the same amount of time is planned for the integration of the client into her new life relations - a process undertaken in co-operation with the personnel of the client's future institution. The consultation period takes place over a far longer time period than this, and contact to former clients often carries on over many years and in the various forms.

The therapy, whether extensive or minimal, for in- or outpatients, is carried out in a 24 hour setting in the rooms of the special education department at the University of Bremen. There we work without personnel or academic and financial support, and with technological possibilities for the theoretical, practical and evaluative side of our work that are well below the necessary standards. We furnish the therapy rooms with our own furniture and other borrowed and collected furnishings. The working materials and aids as well as the planning of the work proper are provided by students in countless meetings and working groups. Here I would hate to neglect thanking the many students whose great involvement far exceeds any requirements the department could set.

We cannot offer our work to a certain region in the form of a supply contract. Work according to DCSCAT stipulations, is generally carried out in projects spanning a three semester time period. Of the many inquiries I receive, only a very few can be attended to. When it comes to choosing the client we will work with, the criterium, so to speak, of the „most serious case" is valid, also in respect to their life conditions. In addition to attempting to develop a new life perspective for the client, the tasks of teaching and research are an equally important component of the work. Meant here is students' training in work with people of this group of persons, as well as gaining knowledge of the questions and issues discussed at the beginning of point 3 in this article.

In conclusion and summary simultaneously, the following thoughts can perhaps be expressed:

from my point of view, it is one of the greatest „deadly sins" of remedial and special education as well as psychiatry that justice is thought to be done to the severity of a disability, to a person's deep-reaching developmental or psychiatric disorder, by reducing the concerned person's life conditions both socially and in terms of content in the fatal belief that the person is thereby enabled a better orientation, an easing of her situation, a quicker recovery and development at all. Quite the opposite: this creates every kind of severe isolation, which is responsible in the first place for the concerned person's coming into the situation which is now to be improved with precisely these measures. Furthermore, this reductionism in terms of socialisation and culture clearly expresses that the concerned individuals have been given up on. In the thinking of MAKARENKO (1964), the highest respect afforded to another human being expresses itself in one's posing great demands of her (while, I would add, guaranteeing her the according assistance). A cardinal error lies in reducing complexity, instead of making it transparent through time-space structuring measures and such measures that relate to objects and actions. To create life conditions for the concerned individuals that are rich socially and in content, to do this on the highest attainable level of our culture while making them transparent through structuring measures and therefore accessible to these individuals: this is the task of therapy. That is: high complexity that is made as transparent as possible!

In this context the basis therapy of DCSCAT is no procedure to address just any disability or to fight just any disorder. Rather, it is the possibility of reconstructing dialogue for a person in that place where this dialogue, through one event or the other, has collapsed and led to near death conditions. It is also the possibility of finding a new „life perspective" and building a new „life plan" *with* the person. In this way, our work also becomes the proof that the problems obliquely referred to with terms such as „beyond therapy", „incapable of education and rehabilitation" or „incapable of social participation" are neither constituted in the person's »nature« nor exclusively caused in the individual.

The ending of that suffering that we cause these persons through exclusion, (this is primary, not the disability) which also goes by the name of remedial and special education, requires first and foremost a radical rethinking, much knowledge and great ability. In the framework of my many years of research and therapeutic work - with people in coma, waking coma (apallic syndrome), with the most severe forms of autism - all the way to work in areas of psychotic personality structures, that which PRIGOGINE and STENGERS (1986) write at the end of their book *Dialog mit der Natur - Neu Wege naturwissenschaftlichen Denkens* has been most impressively elucidated to me: „Today we are beginning to understand what an internally active world means, and thereby gradually grasp how unknowing we still are" (p. 311).

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