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Foundations for inclusion

The storied Hellbrügge program comes to the U.S. at last

BY **TRISHA WILLINGHAM**

We all know that Maria Montessori started her work with atypically developing children, saw great results, and then put her energy into bringing her method to mainstream children.

Somewhere along the way, many of us in America have forgotten that a Montessori education is for every child.

Yet there have been some educators who sought to stay close to Montessori's original vision. In the 1960s, Dr. Theodor Hellbrügge (1919-2014), a German pediatrician who focused his research on child development partnered with Mario Montessori to revolutionize the medical community's approach to the development of children, taking a more holistic approach to children's health, and using Montessori as the vehicle. In 1991, Hellbrügge created the Theodor Hellbrügge Foundation "to teach, practice and promote Social Pediatrics and Developmental Rehabilitation to help children with disabilities around the world, through early diagnosis, therapy and social integration in families, kindergarten and school."

In 1971, Hellbrügge worked with Mario Montessori to offer an Inclusive Montessori Education Course. Although Hellbrügge and AMI parted ways in 1996, the training academy in Munich, *International Academy for Developmental Rehabilitation and Pediatric Training*, provides courses and training to share the Hellbrügge legacy with pediatricians, psychologists and educators around the world. This summer, faculty from the Academy came to Milwaukee, Wisconsin, to share their work with the U.S. Montessori community.

It may seem strange that a Montessori revolution would start in the medical community. But consider the differences among children that Montessori educators observe. Many of them are based on physiological differences children were born with. Others are due to events in the child's life, but they too have a physiological basis. And of course, Montessori has always been a scientifically-based pedagogy—Dr. Montessori was a physician herself.

Today, there are educators in the U.S. working to maintain and enhance inclusive Montessori education. Montessori Medical Partnerships for Inclusion is a membership association of Montessorians, medical professionals, families, and Montessori school leaders lead by Catherine Massie and Barbara Luborsky. The organization is based in Maryland and comprises many experts from the U.S., Canada, and Australia as well as Munich, Germany.

This summer's session was an intensive two-week, 80-hour course for Montessorians of all trainings with the goal of bringing the concept of inclusion closer to the ideal in the U.S., using principles pioneered by Dr. Hellbrügge. It was largely composed of developmental lectures by distinguished medical professionals who had medical expertise, Montessori Inclusive education training, and Montessori therapy training. They showed attendees how these three areas of knowledge can mutually support one another for the child's benefit. The course also offered practice in adapting Montessori lessons and hands-on experimentation with therapeutic practices that can be used with children.

I was fortunate enough to attend the course. Here I summarize some of the key conclusions, in the hopes that many will strike a chord, and readers will see the possibility of better education of atypical learners in Montessori Classrooms.

The long-term goal is to move from integration to inclusion

Integration is welcoming atypically developing children into our environments; that's the current state in many Montessori classrooms. Inclusion, however, means our environments are prepared to meet the needs of all children.

Teams of specialists must work together because you can't separate the pieces of a child

Pediatricians, psychologists, therapists, parents, and Montessori guides all share input, observations, and knowledge and come up with agreed-upon goals. The parents' voice is the most important because they spend the most time with the child. In Munich, they go so far as to house all elements in one place: the University, the school, the hospital, the therapists and even housing for families when intensive therapy is needed.

A deep understanding of development is needed and used for assessment

What is typical, and how does this child compare to typical development? How can we support them in getting

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to the next step? Sometimes the sequence we learned in our Montessori training works for a child with atypical development, so we try that first. But sometimes the child may not progress as we would expect. Our observations as Montessori teachers will then need to be supplemented by medical observations and perhaps evaluations to determine the sources of the child's developmental hurdles. Without the input of medical specialists, we cannot confirm the root causes that need to be addressed for the child to reach his/her developmental potential.

Montessori materials are extremely versatile and powerful developmental tools

They are developmental aids and we know how to use them for typically developing children. If a child is not able to use them as presented, we do what Maria said to do: we observe and we experiment. We adapt our lesson so that the child can feel success. The presentation may be adapted for the depth of concept (for example, using three cubes instead of ten) or length of presentation (for example, just setting the lesson up and then putting it away). Do we need to break down the lesson into smaller lessons or create a precursor lesson? Do we need to give language along the way?

As soon as you see something—a child not following typical development—you need to pay attention. Observe. Ask a colleague to observe. You don't need a diagnosis to begin making individualized adaptations to the lesson procedure or materials. It doesn't hurt to try. We need to start early and keep at it. If the child continues to struggle or not progress, then meet with the parents and bring in the appropriate medical specialists for observation, evaluation, diagnosis and initiate the appropriate therapies to help the child. Don't wait, hoping the child to grow out of the difficulty, because precious early intervention windows will close.

Inclusion, however, means our environments are prepared to meet the needs of all children.

Schools should plan carefully for classroom makeup

There should be a diversity of children, like a tiny micro-community. By the same token, we shouldn't ever feel bad for spending more time with one child. Guides should go where they are needed. If we truly think that we can't meet the needs of a child, it would be because we already are serving the needs of other children who require more time and attention. It would not because of the limitations of the child, it would be because of the limitations of the classroom community itself. Thus, ideally, there should not be more than 25 percent of atypically developing children in each classroom.

Children want to learn from other children

If we support children working together, all children benefit. The child that needs help is the obvious benefactor, but let's not forget that working with someone helps to solidify your knowledge and provides social and emotional growth opportunities. Collaboration, communication, and organization are enhanced through this work as "teacher." We as guides know this, but it's easy to forget because it's often easier to do something ourselves.

I came to the Inclusion course with a strong Montessori background and lots of experience working with children who aren't textbook cases. I found the course to be rigorous and intriguing and I walked away with clarity about what I can do to move this work forward. We are here to meet the needs of all children. Won't you help me with this very important work?

To learn more, come to the *Virginia Montessori Association 2019 Fall Conference—Inclusion: Preparing the Adults and Supporting the Children*, on November 16 at the University of Mary Washington. You can also visit the Montessori4inclusion online at montessori4inclusion.org.

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