

1 AccessAllAreas – where to and why?

Ten years ago, the UN Convention on the Rights of Persons with Disabilities entered into force in Germany. Its goal is a society accessible to all, a society in which people with disabilities can participate in the community as equals and free from discrimination.

For a long time, ‚disability‘ was perceived primarily as an individual medical ‚problem‘: impairments affecting the body, the senses, the mind or cognitive development were to be treated, compensated for or concealed.

This view has undergone some change: for several decades now, the social aspects of disability have been coming to the fore. In many situations it is the social, political, legal, structural or attitudinal barriers that impair a person. In the interests of an inclusive society, the needs of people with disabilities must be taken into account more in the future, and existing barriers reduced.

The ‚AccessAllAreas‘ exhibition aims to contribute by trying to raise awareness of historical and contemporary debates around disability and to counteract prejudice. You don't need a VIP pass to AccessAllAreas, however! It just takes a change of attitude.

2 Normality as a barrier

2.1 Numbers, facts ... and people

Norbert, Leah and Anke – what do these three have in common? Not much at first glance. But whenever ‚people with disabilities‘ are talked about in newspaper articles, political speeches and statistics, these three are also being talked about. All three of them carry the official ‚severely disabled‘ ID card.

This card is a prerequisite for accessing tax concessions and a wide range of other benefits in everyday life. In this context, statistics and standards are necessary to assess need and allocate social benefits.

But thinking in terms of statistics, standards and averages can also exclude, stigmatise and discriminate. It can hide from view what really matters, and blur important distinctions.

2.1.1 How many fingers on the hands of the average German?

It is considered normal to have ten fingers. And most Germans actually do. The average, however, is lower. Those with fewer than ten fingers, while not meeting the physical standard, may therefore still lie within the average – and therefore be considered statistically ‚normal‘.

2.1.2 We are in the minority!

Each and every one of us is part of a minority – whether involuntarily or of their own free will. But not every minority is valued in the same way: some are considered disadvantaged or deficient, others are seen as normal or even as an elite. Some minorities are louder and more visible, while others recede into the background and become stigmatised or ignored. Because the society often follows the needs and opinions of the majority, protecting minorities is an important achievement.

2.1.3 Typically disabled?

What comes to mind when you read the term ‚person with a disability‘? A person in a wheelchair, someone with trisomy 21, or a deaf person? A broad range of impairments exists: it includes the body, the senses, mental health and cognitive abilities.

The ‚handicaps‘ that people are born with number the fewest because most are acquired during the life course – through accident, illness or old age. As different as the types of disability are the people affected by them, their needs and views.

2.1.4 Obstacles wherever you look ...

All people encounter barriers in their lives. But what makes a barrier become a ‚disability‘? According to the German Social Code, people are considered disabled if their physical, mental or emotional health deviates from the state of health typical for their age for longer than six months, and if their participation in society is restricted as a result. This definition leaves room for grey areas – and is by no means uncontroversial. Alternative definitions take social barriers into account more strongly.

2.1.5 Disabled, is that all there is?

In everyday interactions, a ,handicap' – especially one that it is outwardly visible – has the potential to overshadow a person's other characteristics and abilities. But the impairment is only one aspect, and it does not necessarily affect all areas of life. This can be emphasised by a careful choice of words: the term ,person with a disability' follows the rules of ,people-first language', which literally places the person first and considers the impairment as secondary.

2.1.6 Disability – it's a matter of degree

The official measuring unit for the level of disability in Germany is called GdB (short for ,Grad der Behinderung'), meaning ,Degree of Disability'. Those with a GdB of at least 50 are considered ,schwerbehindert' (,severely disabled'). But how can limitations be quantified? This decision is put into the hands of medical examiners and guided by legislation. The effect of the impairment on the life of the affected person is primarily taken into account. Sometimes these classifications are challenged – for example when the person's subjective perception of their impairment contradicts medical findings.

2.1.7 How disabled do you want to appear?

Only those with a disability ID card are considered ,severely disabled' also for statistical purposes. But not all those with a legitimate claim actually apply for the card. Some do not want to be considered disabled because they fear stigmatisation, or because they do not see themselves as ,disabled' at all. This especially affects people with invisible or acquired impairments. As the terms ,severe disability' and ,severely disabled ID' are perceived to have negative connotations, they regularly meet with criticism.

2.1.8 Able-bodied, or just not-yet-disabled?

Disability is a phenomenon of ageing. The fewest impairments are those that people are born with, while most of them are the result of illness in old age. Demographic change presents our society with enormous challenges. The concept of inclusion therefore not only responds to current needs, but also anticipates future requirements. The lift being installed today may well be the one we are all going to depend on tomorrow.

2.2 Prejudice and putting your foot in it

Everyone carries prejudice – including people with disabilities. Thinking in categories provides a structure to everyday life and reduces mental stress. This only creates problems if we are not prepared to question our own assumptions and adjust them to new experiences.

We are not always aware of our prejudices – perhaps also because not every prejudice or judgement is perceived as devaluing. At times, especially public media reporting about people with disabilities vacillates between the two polar opposites of ‚pity‘ and ‚hero worship‘. Easily ignored is the fact that even well-meaning attributions may be inaccurate or unwanted.

On the one hand, conversations about people with disabilities are often characterised by the use of language clichés. On the other hand, being overly fearful of ‚putting your foot in it‘ stands in the way of relaxed interaction. People without disabilities also have to overcome barriers here – and, when in doubt, just ask!

3 Rear vision

A glance in the rear vision mirror sharpens the view for the present. Which terms and concepts of disability existed in the past? How did they change over time? How did earlier societies deal with people who deviated from the ‚norm‘? How did medical and technical developments influence how physical and intellectual impairments are viewed?

This exploration begins in the Middle Ages and extends to the present day. The focus is on the Erlangen region. Wherever possible, biographical information is provided to showcase the lives and fates of people with disabilities in their respective historical period. Even into the 20th century, however, the often already thin trickle of handed-down sources rarely reflects the perspective of those ‚affected‘.

3.1 ‚Lame‘, ‚blind‘, ‚dumb‘, ‚fool‘ – middle Ages and the early modern era

The term ‚disability‘ didn‘t take hold until the 20th century. In the Middle Ages and the early modern era, there was no collective term for physical and intellectual impairments. ‚The lame‘, ‚the blind‘, ‚the dumb‘ and ‚fools‘ were targets of ridicule, exclusion and superstition because of their otherness.

Due to poor living conditions and frequent wars, physically disabled people were a common sight. ‚Lunatics‘ and ‚madmen‘, however, were often imprisoned. The living conditions of disabled people were mainly dependent on the economic situation of their families. Only over time did institutions devoted to the care of the poor and the sick emerge.

Medical knowledge regarding physical and intellectual impairment was very limited until modern times. It was often built on ancient Greek-Arabic theories such as the ‚theory of the four humours‘. Based on this theory, ‚weakness of the mind‘ and mental illness were attributed to an excess of ‚black bile‘ (‚melancholia‘ in Greek).

3.1.1 Faith and superstition

For a long time, no separate form of care existed for people with disabilities. Unless cared for by their families or able to earn a living through paid work, people relied on begging and charity. They therefore found themselves – as did others who were destitute, such as the elderly, the sick or widows – at the bottom margin of the society.

Up until the late Middle Ages, only the church took care of those in need. It saw ‚caritas‘ – charity - as its most important secular task. Its origins lay in the biblical commandment of active compassion. Monastic and church gates, bishoprics and pilgrimage sites were places where alms were distributed; the first hospitals were also built in the vicinity of churches. People with intellectual disabilities, who were often considered ‚obsessed‘, were mostly excluded from church-based charity.

3.1.2 Hospitals and foundations

From the 13th century, the wealthy citizenry of the ascending cities emerged as founders of hospitals. One of their motives was to be assured of their own ‚salvation‘. These extensive foundations benefited the elderly and the sick, as well as people with disabilities.

Over time, social welfare was placed under municipal administration and subject to strict conditions. Poor Laws regulated begging in the cities. Frequently, a person’s long-term ‚city residency‘ was a prerequisite for being issued a ‚beggar’s permit‘. This excluded the many wandering ‚war cripples‘ from receiving alms. In addition, only the poor who were unable to work were entitled to support. Those who were able were forced into work. In Erlangen, it was only in the 17th century that a hospital was built for the Huguenot community, and several Poor Laws were passed as late as the 18th century.

3.1.3 Doctors and quacks

The options for the medical treatment of disabled people remained modest until well into modern times. Infants with congenital impairments had little chance of survival. In cases of loss of limb, simple prostheses provided some support, and the threat of blindness through cataracts was treated by couching. In addition to trained ‚surgeons‘ and physicians, there were also charlatans who moved around the country peddling their questionable treatment methods.

In case of ongoing dependency on care, the sick and the disabled were looked after in hospitals, and in cases of risk of infection in special places such as leper hospitals. Separate buildings also existed for the ‚mentally insane‘. They were places for ‚safekeeping‘ and locking away rather than medical care, especially since facilities such as the Nuremberg ‚Narrenhäuslein‘ (‚fools‘ cottage) also served as prisons.

3.1.4 Stephan Farfler (1633–1689)

Stephan Farfler from Altdorf near Nuremberg was left with paralysis of the legs after a fall at the age of three. Around 1655, when he no longer wanted to be carried to church by his parents, he developed a vehicle with a crank drive, which he could operate himself. His mechanical skills – Farfler was a respected watchmaker – worked in his favour in this instance.

This unusual trolley cart, which can be regarded as the forerunner of modern wheel-chairs and handcycles, made his inventor famous beyond his local region. After Farfler’s death, the vehicle was put on display in Nuremberg.

3.1.5 Matthias Buchinger (1674–1739)

Matthias Buchinger from Ansbach was born without forearms or legs. Hidden from public view by his parents, this talented artist sought the limelight from an early age. An appearance in Nuremberg was denied him, however, as the city council feared that catching sight of him could harm pregnant women and lead to malformations in unborn children.

Buchinger achieved greater success in England, where from 1717 onwards he became famous under the sobriquet ‚Little Man from Nuremberg‘. Kings and the Emperor were among his admirers during his European tours. When Buchinger died in 1739 at the age of 65, he left behind 14 children by eight women.

3.2 Healing, caring, education – 19th century

Since the Enlightenment, perspectives on people with disabilities began to change: tradition and superstition were replaced by exact observation and scientific experiment. 'Insanity' was diagnosed as a brain disease for the first time. Blindness and deafness were no longer regarded as divine punishment, but as organ defects.

Based on their aspirations to provide care and healing, physicians founded novel institutions, such as 'blind' and 'deaf-mute' facilities, where 'special pedagogy' methodologies were pioneered. Deaf and intellectually disabled people in particular were now recognised as 'capable of learning'.

The priority for these institutions was education in order to achieve earning capacity. People with disabilities were supposed to make as much of a contribution to their own care as possible. Those who wanted to find shelter in a social institution had to work in return. This 'paternalistic' approach characterised social services systems into the 20th century.

3.2.1 Beginnings and reforms in psychiatry

Until the beginning of the 19th century, 'insanity' and 'idiocy' were considered untreatable. This changed when physicians began to regard mental disorders as diseases of the brain. New research findings contributed to the establishment of psychiatry as an independent discipline.

Novel facilities were no longer intended to keep 'lunatics' and 'morons' in custody like delinquents, but designed to use trained personnel to care for, and, if possible, cure them. At the same time, these institutions served as research facilities and practical, 'on the job' training establishments. One of the pioneers of the Bavarian institutional system was Johann Michael Leupoldt, Professor of Theoretical Medicine in Erlangen. His tireless efforts contributed to the fact that, in 1846, the first 'District Lunatic Asylum' of the Kingdom of Bavaria was built on Maximiliansplatz.

3.2.2 Psychiatric treatment methods

Despite advancements in medical knowledge, treatment methods that were considered modern around 1900 seem questionable from today's perspective. Asylum doctors thought that spa treatments lasting for hours on end held the most promise. Restless and aggressive patients were restrained using fetters, straitjackets or crates. So-called 'therapeutic machines', such as rotating chairs and beds, were also used. These devices kept 'inmates' in motion to the point of exhaustion.

Until the development of new treatments, such as the 'electroshock' therapy (now called electroconvulsive therapy or ECT) used from the 1920s onwards, and the introduction of effective psychoactive drugs in the mid-20th century, the range of therapeutic methods remained limited. Reform initiatives such as the 'open care' approach, which originated in Erlangen, were pushed back under National Socialist rule.

3.2.3 Schooling for the blind and the deaf

In Nuremberg, special schools for the blind and the deaf were created from the early 19th century, initially as private initiatives. These institutions sought to provide students with knowledge and skills for an independent life. However, many students remained as employees of the in-house workshops after graduation.

These schools were centres of innovation for the development of technical aids. In some areas, however, they also had an inhibiting effect: the use of sign language, for example, was prohibited in most 'deaf-mute schools' well into the 20th century. According to the 'oralism' doctrine, deaf children were supposed to only learn spoken language and lip-reading, while signing was ridiculed as 'monkey language'.

3.2.4 Paul Ritter (1829–1907)

The school of the Nuremberg Center for the Hearing-impaired today bears the name of the painter Paul Ritter, who lost his hearing as a result of scarlet fever at the age of four. Born in Nuremberg, he attended the 'Deaf-Mute School' in Winklerstraße and studied painting and graphic design at the Nuremberg School of Applied Arts.

Well known as a painter of large-scale architectural and historical paintings, Ritter also made his mark as an activist of the ‚deaf-mute movement‘. With great commitment he fought for the recognition of deaf people and founded the ‚Deaf-Mute Society‘.

As professor at the Academy of Fine Arts, he carried out his duties with the support of his brother Lorenz, who interpreted for him. Paul Ritter, who remained unmarried and childless, died in 1907 at the age of 78.

3.2.5 Special schools for children with intellectual disabilities

While schools for the deaf and visually impaired had been widespread in Germany since the 19th century, schools for students with ‚learning difficulties‘ and ‚intellectual disabilities‘ only gradually emerged. For a long time, children were ‚hidden away‘ at home or – with little success – taught at ordinary schools.

With the introduction of compulsory education in Bavaria, the proportion of students with ‚learning difficulties‘ increased. However, considering class sizes of up to a hundred children, targeted support was out of the question. For this reason, the City of Erlangen offered ‚tutoring courses for idiotic children‘ starting in 1905. In 1919, after being delayed by the First World War, an ‚auxiliary school‘ with two classes opened in Friedrichstraße. Until the 1960s, auxiliary school classes in Erlangen were dispersed across various buildings.

3.2.6 ‚Heinerle from Lindenbronn‘

The silent film ‚... und hätte der Liebe nicht‘ (‚... and would not have of love‘) from 1927 tells the story of the young ‚Heinerle from Lindenbronn‘, who retained a walking impairment after suffering from ‚infantile paralysis‘. On the advice of the village priest, he travels to Altdorf with his mother to be examined at the local ‚Wichernhaus Home for Cripples‘. The orthopaedic physicians there are confident that they can alleviate Heinerle’s complaints. For the boy, admission to the ‚Home for Cripples‘ – at that time one of the most modern facilities of its kind – means the painful separation from his family. The treatment, however, pays off: with the aid of a prosthesis, Heinerle learns to walk upright.

3.3 ,War cripples‘ and ,shell-shock‘ World War I, 1914–1918

The First World War revealed the destructive potential of wars conducted on an industrial scale in a disturbing way. Millions of soldiers fell on the battlefields, thousands and thousands had to reclaim their former lives with severe injuries, and physical as well as psychological impairments.

For the first time, society had to deal with the reintegration of disabled people as a matter of principle. The ,war cripples‘ were not going to be ignored: as begging invalids they served as painful reminders of the traumatic defeat in the war and were at times punished with contempt. Social democrat Erich Kuttner wrote that ,even patriotism gives these people a wide berth‘.

Many of those affected joined forces as interest groups and party-political organisations to draw attention to their lot and state their demands. Founded in 1919, the ,Imperial League of War Wounded, War Veterans and Their Surviving Dependants‘ counted over 800,000 members in 1922.

3.3.1 The ,war cripples problem‘

The millions of permanently injured soldiers did not feel sufficiently appreciated for the sacrifices they made during the war. Although the state tried to provide adequate compensation, many war wounded slipped to the bottom margin of the society. Inflation and the Great Depression contributed to their financial distress.

Stronger than efforts to create lasting social security was the State’s desire for an ,un-crippling of the cripples‘: with the help of medical advancements, the ,war damaged‘ were to be ,restored‘ in order to be fit for work. Those who did not meet performance expectations were sometimes considered unmanly or ran the risk of being defamed as ,pension scammers‘ or ,parasites‘.

3.3.2 Military hospitals and ,cripple care‘

Within the first year of the war, hospital trains returning from the front brought many, often seriously injured soldiers to Erlangen. More than 1,800 hospital beds were made available for them in clinics and other rooms at the university. Loss of limb was one of the most common war injuries. Orthopaedic exercises were intended to achieve the rapid rehabilitation of these ,war cripples‘. They began practising to use their new artificial ,replacement limbs‘ while still at the military hospital.

To further assist the invalids, a War Welfare Committee was set up to develop vocational training and retraining measures. Local companies were intended to provide ,cripple-friendly‘ jobs, and fundraising campaigns were run in the press. Private charity was understood as a ,patriotic‘ duty.

3.3.3 Military psychiatry during World War I

During the First World War, an unexpectedly high number of soldiers became mentally ill. Those affected responded to the stresses of serving at the front with paralysis of the limbs, becoming blind or deaf, twitching, trembling or becoming mute.

Military psychiatry collectively termed these symptoms ,war neurosis‘, ,war hysteria‘ or ,nervous shock‘. Psychiatrists and neurologists sometimes developed draconian therapies to ,force the soldiers into recovery‘ and restore them for front-line duty.

Many doctors excluded the possibility of any connection between mental suffering and the experience of war. They saw ,war neurosis‘ as a result of hereditary disposition or lack of willpower. This way of thinking continued for some time: during National Socialism, mentally ill veterans were vilified as ,weaklings‘ and ,malingerers‘.

3.4 ,Ballast existences‘ and ,unworthy lives‘ Nazi Germany, 1933–1945

One of the substantive objectives of the Nazi regime was the creation of a racially homogeneous, healthy and productive ,national community‘. On the one hand, people of ,high racial value‘ were promoted. On the other hand, people who were considered ,inferior‘ were to be ousted and ,eradicated‘.

The Nazi ,hereditary health policy‘ was based on ideas taken from eugenics and ,racial hygiene‘, which had been widespread – not only in Germany – since the 19th century. The ,life value‘ of a person was measured not least for its economic benefit. Nazi propaganda stigmatised people with disabilities that were permanently living in institutions as ,ballast existences‘. People suspected to have ,hereditary disease‘ were at risk of forced sterilisation.

Hundreds of thousands of people with physical and intellectual disabilities as well as mental illness fell victim to this policy: they were rendered infertile against their will and, from 1940 onwards, systematically murdered.

3.4.1 Forced sterilisation of people with ,hereditary disease‘

On 1 January 1934, the ,Hereditary Disease Prevention Act‘ (GzVeN) came into force. From then on, every doctor in Germany was called upon to report persons with ,hereditary disease‘ and thus initiate the sterilisation process. ,Hereditary Health Courts‘ were charged with making decisions on sterilisation.

The following diagnoses were defined by the Act as ,hereditary diseases‘:

- ,Innate idiocy‘ (intellectual disability)
- ,Schizophrenia‘
- ,Circular (manic-depressive) insanity‘ (bipolar disorder)
- ,Hereditary epilepsy‘
- ,Hereditary chorea‘ (Huntington’s Disease)
- ,Hereditary blindness‘
- ,Hereditary deafness‘
- ,Severe hereditary physical deformity‘

In addition, marginalised groups such as criminals, alcoholics, prostitutes and the homeless could also be considered to have ,hereditary disease‘.

Sterilisation laws also existed in other countries. The fundamental difference of the Nazi Act was the involuntary nature and mass application of this intervention. Until 1945, about 350,000 people were forcibly sterilised, and of those, 5,000 to 6,000 women and about 600 men died as a result of the operation.

3.4.2 Anna P. and Johanna N. – forced sterilisation victims

Of the more than 500 women who were sterilised at the Erlangen University Women's Hospital, two are proven to have died as a result of the surgical intervention:

Anna P. was admitted to the gynaecological clinic on 10 July 1935. She was 16 years old. The 'Hereditary Health Court' in Nuremberg had ordered sterilisation because of 'innate idiocy' and 'deaf-muteness'. The medical records state that, because of the patient's 'deaf-muteness', the doctor was unable to take a medical history. Anna P. was operated on immediately and then transferred to the Treatment and Care Asylum. She died there three days later of 'heart failure in an acute state of excitement'.

28-year-old Johanna N. was forcibly sterilised at the Women's Hospital in Erlangen on 13 December 1937. The ward doctor noted that 'given the patient's high-grade idiocy, no precise medical history can be taken.' A few hours after the operation, the patient suddenly 'started to rage and scream loudly'. After being administered an opiate, Johanna N. passed away at the hospital.

3.4.3 Killing people with intellectual disability and mental illness

During the Second World War, the German psychiatric system became the crime scene of mass murder. As part of the 1940 T4 'euthanasia' campaign – named after the central unit responsible for it and housed in Tiergartenstraße 4 in Berlin – more than 70,000 intellectually disabled and mentally ill people were centrally listed, selected, deported and gassed in 'killing facilities'.

After this 'euthanasia' campaign was stopped – in part due to public protest – the killing continued decentralised at the individual institutions. From 1941 onwards, patients died from intentional overdoses and systematic malnourishment. The Bavarian 'Starvation Diet Decree' ordered the administration of a fat-free diet to psychiatric patients who were 'unfit for work'. Some 300,000 people in total fell victim to the Third Reich's various 'euthanasia' campaigns.

3.4.4 Hubert D. (1891–1941) – ‚euthanasia‘ victim

Hubert D. from Herzogenaurach was a trained brewer, but had to give up this job because of a congenital heart defect and subsequently ran a tobacco store in his hometown. After he had insulted Propaganda Minister Goebbels at a pub in 1937, an Erlangen psychiatrist diagnosed him with a ‚mental illness (schizophrenia)‘. This caused Hubert D to become subject to the sterilisation law: he was sterilised against his will in 1938. One year later he was transferred from the Erlangen University Psychiatric Department to the Treatment and Care Asylum. Hubert D. was denied his desperate wish to return home. His wife turned her back on him. On 24 June 1941, he was deported from Erlangen to the Austrian ‚killing facility‘ in Hartheim near Linz, where he was gassed.

3.4.5 The critical reappraisal after 1945 of Nazi medical crimes

‚Denazification‘ after the end of the war was not very successful in Erlangen either. Psychiatrists in institutions and university physicians involved in Nazi medical crimes often returned to their old posts or opened thriving private practices. Hardly anyone was prosecuted. A ‚euthanasia‘ trial launched in 1946 did not result in a conviction.

Although the ‚Hereditary Disease Prevention Act‘ was suspended after the end of the war, it was not classified as a Nazi injustice until 2007. Until today, the women and men forcibly sterilised under the Act are not recognised as victims of Third Reich persecution. As ‚second-class‘ Nazi victims, their claims for compensation are – if they exist at all – marginal.

3.5 Advocacy groups and parents' initiatives – New beginnings in the postwar period

In 1950, more than 70 % of people with a disability in Germany were wounded veterans, called ‚Kriegsbeschädigte‘ (literally: ‚war-damaged‘). Forming influential advocacy groups, they had already fought for and won social benefits for veterans and their dependents in the early post-war period.

Parents of people with intellectual disabilities had long felt abandoned by politics and the society. The ideological fallout from the Nazi era was still being felt. Until far into the 1950s, people with intellectual disabilities were called ‚morons‘, and, following the ‚Third Reich Compulsory Education Act 1938‘ – still in force at the time –, excluded from school attendance. This deplorable state of affairs led parents of affected children to take charge of their own interests through initiatives such as the ‚Lebenshilfe‘ (lit. ‚Life Help‘) charity.

Not until the 1960s and 1970s did a change in social values lead to fundamental structural reforms in many areas, such as in psychiatric care and the development of the special school system.

3.5.1 Advocacy for injured veterans

In 1947, more than 100 physically disabled war veterans and their relatives came together as the local chapter of the VdK, the ‚Veterans, War Injured and Pensioners Association Inc.‘, in Erlangen. Under its motto ‚United, even the Weak are Strong‘, the VdK became a pioneer for improving the economic situation of the ‚war-damaged‘.

From the 1960s onwards, the association opened its doors to all people with disabilities, as well as to all pensioners. Today it advocates for the social policy interests of its nearly two million members. The Erlangen-Höchststadt branch has over 10,600 members.

3.5.2 ‚Lebenshilfe‘ – a parents‘ initiative

The ‚Lebenshilfe (literally: ‚Life Help‘) for the Developmentally Inhibited Child‘ in Erlangen was founded in 1960 as the first local branch in Bavaria. Two years later, the Bavarian State Association also set up its headquarters in Erlangen. The initiators of the Erlangen branch included parents of intellectually disabled children who, in the absence of government services, wanted to benefit from self-help assistance. They received support from doctors at the University’s Children’s Hospital and special needs educators.

Not only in Erlangen, the Lebenshilfe organisation was able to achieve remarkable successes – e.g. by establishing special education child care centres and schools. Shortly after being founded, the Federation of State Lebenshilfe Associations advocated for the creation of the Federal Social Assistance Act of 1962, which was the first to articulate a right to assistance services.

3.5.3 Continuity and reforms in psychiatry

In the post-war years, psychiatry suffered a breakdown of trust as severe as hardly any other medical specialty. Its institutions, above all its ‚Treatment and Care Asylums‘, had become the crime scenes for the murders committed on patients during the Nazi era. Despite this, most reform proposals initially went unheard.

Only 30 years after the end of the war did the 1975 ‚Report on the State of Psychiatry in the Federal Republic of Germany‘ lead to fundamental improvements in the structure of care. Conditions in psychiatric ‚asylums‘ were judged inhumane. The report recommended that patients increasingly be treated in smaller, community-based facilities and supported in outpatient mode. The ‚Erlangen District Hospital‘, successor to the local ‚Treatment and Care Asylum‘, was the last large-scale psychiatric institution built in Germany.

3.6 “Cripples are Hitting Back!” – self-determination and participation

The ‘International Year of Disabled Persons’ in 1981 prompted people with disabilities worldwide to raise awareness of social ills. Especially younger people insisted on the right to live, study and work independently. Using the provocative slogan ‘Jedem Krüppel seinen Knüppel’ – ‘Cripples are Hitting back!’ (literally: ‘give every cripple his truncheon’), they declared war on what they called ‘the disablers in politics and society’.

Using spectacular stunts, the movement succeeded in penetrating the public conscience. The prevailing medical view of disability gradually expanded into a holistic picture that incorporated social barriers. Administration, politics and society were sensitised to the needs of people with disabilities. Accessibility, participation and reforms of psychiatric care came into focus.

Thanks to the international networking of self-help organisations, representatives of the disability movement eventually became co-organisers of the 2006 UN Convention on the Rights of Persons with Disabilities.

3.6.1 The self-determinators

In 1977, students with disabilities in Erlangen joined together to form the ‘Student Initiative on Disabled Persons’ (StIB) to enforce accessibility in the areas of housing and studying. As a result of persistent negotiations with student services and municipal offices, ramps, lifts and disabled parking spaces were set up, kerbs dropped and accessible student apartments built at the university.

In 1988, the ‘Centre for Self-Determination in Disability’ (ZSL), one of the first facilities of its kind in West Germany, emerged from the StIB. The ZSL advises people with disabilities and brokers individual assistance. The umbrella organisation ‘Advocating Self-determined Life in Germany’ (ISL), founded in 1990, also had its headquarters in Erlangen until 1997.

3.6.2 “wabe”

The ‚wabe‘ (honeycomb) association was founded in 1987 by employees of the Erlangen District Hospital to help people with a mental illness integrate into society and offer them perspectives for a self-determined life.

The association runs a home support service, a therapeutic residential facility and a recognised workshop for people with psychological impairments. ‚Wabene‘, a drop-in centre with a focus on inclusion, was established in 2012.

3.6.3 Erlangen on the path to inclusion

When the City of Erlangen’s first disability commissioner took up his duties in 1985, he only had 23 colleagues in the entire civil service across the Federal Republic. Inspired by activists from the disability movement, Erlangen also took on a pioneering role in other areas: creating housing with disability access, dropping kerbs and purchasing low-floor buses were important steps on the way to inclusion. In 1998, the city council decided that all future municipal new and remodelled buildings must have disability access.

Over the past ten years, the implementation of the UN Convention on the Rights of Persons with Disabilities has been understood as a major political task across all political parties. In 2016, the municipality set up an Office for Equal Opportunity and Diversity, which maintains a Special Unit for Inclusion and Diversity. Since 2017, Erlangen has been one of Germany’s five model municipalities participating in the ‚Inclusive Communities‘ initiative of the ‚Aktion Mensch‘ charity.

3.6.4 Joseph Greil, the ‚UN General‘ (1903–2000)

Since 1930, Munich-born Joseph Greil had been an inpatient at Erlangen’s ‚Treatment and Care Asylum‘, for which he performed motorbike messenger services on ‚day release‘. Tongue in cheek, the public used to call him the ‚UN General‘, for around town he presented himself as ‚political advisor‘ to the ‚world government‘. Wearing uniforms of his own design, he had been campaigning for the reunification of Germany since the 1950s, and used to give well-attended lectures at the university.

The ‚UN Legion‘ founded by him counted the Erlangen psychiatric institution’s director Werner Leibbrand among its supporters, while President Truman and Stalin were listed as honorary members. This local icon spent his later years on the Eggenhof estate near Uttenreuth, which had also been part of the former Treatment and Care Asylum.

3.6.5 Klaus Kreuzeder (1950–2014)

Klaus Kreuzeder was born in Forchheim and grew up in Altdorf near Nuremberg. After suffering from polio at one and a half years of age, his legs had remained paralysed. To train his weakened lung, he used to play the recorder as a child, an instrument he traded for a saxophone as a teenager. Since that time, music ruled his life. In 1972, Kreuzeder celebrated his first successes as a member of the jazz-rock band ‚Aera‘, and as a sought-after solo saxophonist he played with Stevie Wonder, Sting and Udo Lindenberg, among others. The long-term effects of post-polio syndrome and contracting cancer forced Kreuzeder to retire from the stage in 2013. He died on 2 November 2014 in Munich.

4. Present-day lived experience

Since 2009, the ‚Participation, not Charity‘ stance of the UN Convention on the Rights of Persons with Disabilities has become legally binding also in Germany. This has made inclusion a task for society as a whole. The right to equality and self-determined participation of people with disabilities has become the focus of concrete political measures.

But what does self-determined participation mean? What threatens it, and how can it succeed? The following section of the exhibition shows, on the one hand, the social and physical barriers that confront people with disabilities in contemporary society. On the other, it also presents successful strategies for inclusive community life.

Everyday lived experience and the realities of life are examined using the examples of communication, partnership, work and mobility. People with disabilities from Erlangen and the region will themselves get to have their say: in personal statements they express their different experiences, needs and opinions.

4.1 Communication

Following current affairs, exchanging ideas and life-long learning are indispensable foundations of social participation. They are prerequisites for equal access to forming and expressing personal views.

Access to knowledge is a human right. The UN Convention on the Rights of Persons with Disabilities therefore demands that information intended for the general public be made available without delay, at no additional cost, and in a range of formats and languages. In Erlangen, the city council decided in 2009 to take greater account of communication aspects in the implementation of accessibility strategies.

But how can you follow a conversation if you can't hear? How can you read a newspaper if you can't see? The possibilities are many: non-existent senses can be compensated for by other abilities, technical aids can overcome ‚communication barriers‘, and special languages can enable comprehensive and lively exchange.

4.2 Mobility

About to quickly step out to get milk or spontaneously make a movie date with a friend? Taking the children to football training or treating yourself to a spa day at the city baths? Even for people without disabilities, these everyday situations lead to practicalities: Do I have the car? Can I afford the entry tickets? How much time do I have before my next appointment?

People with disabilities usually face significantly more questions – and significantly more barriers. Overcoming them often requires a considerable amount of time, research and organising.

On the way to an inclusive society, there are a lot of ‚road works‘ to get around – be they literally on the road, or even in your own home. Countless restaurants, hair salons, banks and even doctors‘ practices still don‘t have disability access. Moreover, changes to physical structures alone are not enough: the ‚care crisis‘ has reached the doorsteps of many service providers and poses great challenges for society.

4.3 Work

A world of work characterised by the efficiency mantra and performance pressures can overwhelm people with or without disabilities. For people with disabilities, it is often difficult to find employment on the open labour market. However, carrying out an occupation is an important prerequisite for participating in social life.

In Germany, a ‚secondary labour market‘ has become established in response: workshops for people with disabilities, formerly intended to be ‚sheltered‘, are now supposed to serve (re-) integration into the ‚primary labour market‘. Because only few employees succeed in making this transition and the pay is low, this workshop model is subject to increasing criticism.

On the topic of work, too, accessibility starts in the mind: too often the focus is not on the applicants‘ qualifications, but on their impairment. To some employers, it appears too laborious or too expensive to accommodate special needs. Instead of complying with the statutory quota for employing people with official ‚severely disabled‘ status, the majority of German companies select to pay the alternative compensatory levy instead.

4.4 Partnership

Dating, everyday life in a relationship and parenting present everyone with challenges. Unrealistic beauty ideals and notions of what ,normal' relationships or families should look like, shape the society. People with disabilities often have to overcome additional barriers. Especially with regard to people with intellectual impairments, sexuality and the desire to have children still seem to be taboo subjects.

But here, too, things are changing. Counselling and support services – from ,supported parenting' to sexuality counselling – open up perspectives and enable self-determination. The UN Convention on the Rights of Persons with Disabilities clearly states that every person with a disability has the right to marry and start a family.

4.5 Visibility

Being visible in everyday life and in the media is a concern for many social minorities. Public representation attracts attention and changes mainstream societal awareness.

Accessibility and inclusion have increasingly moved into the focus of politics and the media in recent decades. ,Disability' has become a topic for countless talk shows, documentaries and feature films – and is not always presented free of clichés. On social media, too, people with disabilities share their experiences, answer questions – and make their own decisions about how they want to present themselves.

That the topic of disability has also arrived in children's bedrooms can be seen in the product range offered by the toy and entertainment industries. The ,image-friendly' marketing of inclusion opens up new consumer groups – while at the same time helping to ensure that diversity is perceived as normal.

5 Looking ahead

,Technological Doping‘ and ,Prosthetic Envy‘

In 2014, the German Athletics Federation refused the runner Markus Rehm a place in the European Championships competition because his leg prosthesis allegedly gave him an illegal advantage. Soon, the ,technological doping‘ catch phrase made the rounds in the media. This case highlights the potential consequences of technological development: what happens when prostheses perform better than the body parts they are replacing? Scientists are already describing the phenomenon of ,prosthetic envy‘, which tempts people to undergo operations that turn them into ,cyborgs‘.

Opportunities and threats of the digital revolution

Networking in the digital space can lower barriers and facilitate the exchange of information. The ,Be My Eyes‘ app, for example, gives blind and visually impaired people access to a network of thousands of sighted volunteers who can assist with everyday tasks. Voice output and ,smart home‘ technologies offer new solutions to existing problems. For participation to become a reality, however, digital services themselves must also be accessible. This applies not only to websites and online forms, but also to hardware components such as the now ubiquitous touch screens.

Medicine and disability – an ambivalent relationship

Modern medicine can make life with a disability possible and easier, but it can also prevent it. Prenatal diagnostics are leading to more and more fetuses with trisomy 21 being aborted. Whether prenatal blood tests in pregnant women should be covered by statutory health insurance was controversially discussed in the spring of 2019. Post-hoc ,correction‘ of impairments is also meeting with resistance from time to time: In February 2019, a court ruled that deaf parents have the right to refuse a cochlear implant for their child who is also deaf.

On the path to an inclusive society

Ten years of the UN Convention on the Rights of People with Disabilities – what has changed in Germany since 2009? The report card is mixed: while society as a whole has become more open to the needs of people with disabilities, the cold, hard facts reveal little progress in key areas. Equal participation in the labour market seems to be a long way off, and inclusion in the education system has become a political bone of contention. People with disabilities often still live in parallel structures that contradict the idea of inclusion. AccessAllAreas is still in its infancy.