Contemporary Special Education in Kingdom of Saudi Arabia: Conceptualization and Service Provision for Profound and Multiple Intellectual Disabilities

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Abstract:

Objectives: This paper investigates how Special Educational Needs (SEN) practitioners in the Kingdom of Saudi Arabia's Comprehensive Rehabilitation Centers conceptualize Profound Intellectual and Multiple Disabilities (PIMDs) and how these views shape service provision.

Methods: Using an interpretive phenomenological approach, semi-structured interviews were conducted with 17 SEN specialists across three governmental centers in Riyadh. Data were thematically analyzed through the lens of the Disability Studies Framework.

Results: Findings highlight persistent terminological ambiguity around PIMDs, which hinders research development and complicates interdisciplinary communication, ultimately limiting the establishment of a clear and unified research foundation and consistent service practices. Where clearer definitions exist, they remain rooted in medical models that portray PIMDs as a permanent deficit state and reinforced by charitable discourses of pity and protection. In contrast, only a minority of specialists employed social, affirmation, and rights-based perspectives, signaling the need for a paradigm shift toward contemporary special education practices.

Keywords:

Disability studies, profound intellectual and multiple disabilities, traditional models of disability, traditional special education, contemporary special education.

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1. Introduction

Historically, individuals with Profound Intellectual and Multiple Disabilities (PIMDs) were often overlooked in education because of their complex needs and significant daily support requirements (Simmons & Bayliss, 2007). Although the global prevalence of PIMDs is unknown, Bellamy et al. (2010) and Nakken and Vlaskamp (2007) noted that prevalence rates have risen over the past two decades due to advances in neonatal care and holistic services. This shift has led scholars, educators, and policy-makers to move away from deficit-oriented models focused solely on nursing and custodial care (Bellamy et al., 2010; Simmons & Bayliss, 2007). Consequently, various terms have emerged across countries to distinguish this group from others with significant support needs, including Severe Disability (SD) and Multiple Disabilities (MDs).

In the United Kingdom (UK), individuals with PIMDs are often described as having Profound and Multiple Learning Disabilities/Difficulties (PMLDs) (Bellamy et al., 2010; Simmons & Bayliss, 2007). In some cases, the term is compounded as “Severe to Profound Multiple Learning Disability,” which typically refers to an IQ below 50. By contrast, “specific learning difficulties” refers to conditions such as dyslexia (Aljaser, 2017). Across Europe, the preferred term is **Profound Intellectual and Multiple Disabilities (PIMDs)** (Aim et al., 2023; Nakken & Vlaskamp, 2007). In Australia, the term **Profound and Multiple Disabilities** is common (Arthur-Kelly et al., 2008; Lyons, 2005), while Japan uses **Severe Motor and Intellectual Disabilities** (Wakimizu & Fujioka, 2024). Medical classifications may also refer to specific syndromes, such as Batten and Rett syndromes (Mencap, 2016). In the United States, however, the broader term *MDs* is still used under the Individuals with Disabilities Education Act (IDEA), encompassing both moderate and severe conditions. This broader category was designed to avoid overly narrow classifications and maintain flexibility in the allocation of financial support (U.S. Department of Education, 2004).

Maes et al. (2020) noted that since 2012, two main terms have dominated the international literature: PMLDs and PIMDs, with PMLDs being more common in the UK. The term PIMDs was first endorsed in 1996 by the International Association for the Scientific Study of Intellectual and Developmental Disabilities (IASSIDD), in collaboration with the World Health Organization, to describe individuals with severe cognitive, neuromotor, or sensory impairments requiring lifelong, intensive support (IASSIDD, n.d.). This study adopts the term PIMDs to align with international literature, capture the neurological complexity of the condition, and provide a clearer framework for examining Special Educational Needs (SEN) practice in the Kingdom of Saudi Arabia (KSA). The lack of consistent terminology leads to unclear definitions, making it difficult to accurately estimate the number of individuals with PIMDs and to distinguish them from other disability groups. For example, the reported 6.4% prevalence rate of MDs among citizens aged 5–35 years (General Authority for Statistics, 2016) is only an approximation, since the category encompasses a wide range of conditions.

In an effort toward conceptual clarity, Nakken and Vlaskamp (2007) defined PIMDs by two core criteria: (a) profound intellectual disability (IQ below 20; developmental functioning at the sensorimotor stage, equivalent to a developmental age of two years or less) and (b) profound motor disability, often involving wheelchair dependence, limited or no hand function, skeletal deformities, and severe difficulties with posture and balance. Individuals with PIMDs may also experience sensory impairments, making touch, smell, and taste essential for interaction. Health challenges may include swallowing difficulties requiring tube feeding, gastroesophageal reflux, and recurrent pneumonia (Bellamy et al., 2010). Communication is typically non-verbal, expressed through body language or responses to familiar voices and touch, with caregivers playing a central role in interpreting intent (Aljaser, 2010). Aljaser (2010) further observed that although some individuals with cerebral palsy may also have intellectual disabilities, they do not necessarily meet the criteria for PIMDs, underscoring the importance of distinguishing between these conditions.

Historically, complex needs framed individuals medically rather than educationally, with professionals prioritizing survival, nutrition, and muscle tone while neglecting learning and communication (Stewart, 2015). In the UK, the 1944 framework classified them as "severely sub-normal," reinforcing the view that they were ineducable (Jones, 2005; Stewart, 2015). Many were institutionalized, performing repetitive tasks or limited play therapy, often confined to wards without stimulation (Byers & Lawson, 2015; Male & Rayner, 2007). Legislative reforms, including the Education (Handicapped Children) Act 1970, the Warnock Report 1978, and the Education Act 1981, shifted responsibility to education authorities, affirming every child's right to learn (Jones, 2005; Male & Rayner, 2007; Stewart, 2015; Tilstone, 1991). Although schools initially mirrored hospitals, prioritizing therapy and care over learning (Orelove & Sobsey, 1991), this period marked a key shift toward recognizing the educational potential of individuals with PIMDs (Byers & Lawson, 2015). Over time, the focus expanded to their capabilities and learning potential (Lacey, 1998; Simmons & Bayliss, 2007). In 1998, SEN teachers began using the P-Scales to capture incremental progress in communication, cognition, and personal and social skills, enabling the setting of realistic targets (Department for Education & Standards and Testing Agency, 2017). The 2020 Engagement Model further assessed participation and interaction, complementing the P-Scales (Aidonopoulou-Read, 2021).

The Special Educational Needs and Disability (SEND) Code of Practice, alongside Education, Health, and Care (EHC) Plans, reinforced multi-agency collaboration by ensuring that educational, health, and social needs were addressed holistically (Department for Education & Standards and Testing Agency, 2017). The Equality Act 2010 introduced a duty for education providers to make reasonable adjustments, including communication support, curriculum adaptation, staff training, and accessible learning environments (Equality Act, 2010). The SEND Code of Practice operationalized these duties by guiding schools on inclusive implementation (Department for Education, 2015). It can be seen that progressive PIMD policies in the UK introduced a new understanding of disability, shifting from traditional deficit-based views to social, affirmation, and rights-based models that view disability as human diversity and focus on environmental barriers rather than individual limitations (Cameron, 2014; Degener, 2016; Sofokleous & Stylianou, 2023; Swain & French, 2000).

Within the Gulf region, Saudi Arabia was an early adopter of disability policy. The 1958 Social and Economic Development Plan recognized the welfare rights of citizens with impairments and established a tri-ministerial framework spanning education, health, and social development (Alquraini, 2010). The 1970 Education Policy Document targeted individuals with intellectual, visual, and hearing impairments. Chapter Eight, Act 5 (Articles 188–189), mandated the Ministry of Education (MoE) to provide tailored curricula that instill Islamic values, foster appropriate behaviors, and develop independence skills. The 1987 Disability Law further established equal rights to education, healthcare, social care, and rehabilitation, requiring public agencies to support independent living. The 2000 Disability Code reinforced nondiscrimination, access to education, health, rehabilitation, and employment (Article 2), and barrier-free public spaces (Article 3). The 2001 Regulations of Special Education Programs and Institutes (RSEPI), comprising 101 articles across 11 chapters, provided a comprehensive framework for schools to ensure consistent, high-quality support for students with disabilities (Regulations for Special Education Institutes and Programs, 2001).

Based on these policy provisions, several government entities provide services for people with disabilities, including the MoE and the Ministry of Human Resources and Social Development (MoHRSD). The MoE offers educational services to students with mild to moderate disabilities—such as intellectual disability, autism, visual or hearing impairments, and behavioral disorders—through special centers or integrated programs in mainstream schools (Ministry of Education, 2025). The MoHRSD oversees 38 Comprehensive Rehabilitation Centres (CRCs), including three for girls in Riyadh that form this study’s focus. CRCs provide rehabilitation, therapy, life skills training, and recreational services for individuals with severe disabilities and PIMDs. The ministry also operates 120 daycare centers across KSA, offering therapy, daily living skills training, and family guidance (Ministry of Human Resources and Social Development, 2025). Despite these initiatives, services remain less developed than in Western countries, reflecting the longstanding belief that learners with very low measured intelligence are better served in rehabilitation centers or long-stay hospitals than in classrooms (Almousa, 2008; Alquraini, 2010). Moreover, SEN research in KSA has paid limited attention to persons with PIMDs. Only a few studies address severe and multiple disabilities, such as Mirza (2012) and Shagdar (2022), while most focus on individuals with MDs (e.g., Alkohaiz, 2018; Almalki, 2017; Almalki, 2022) or SDs (e.g., Abu Alghayth, 2019; Aldabas, 2020; Almalki, 2013; Alquraini, 2017; Alquraini & Gut, 2012; Shugdar, 2019).

The current study focuses on girls and women with PIMDs in CRCs in Riyadh, examining practitioner beliefs and the prevailing models of disability shaping contemporary special education. This aligns with Saudi Vision 2030, which seeks to improve the quality of life for all citizens. Within this agenda, the Authority for the Care of People with Disabilities, established in 2018, empowers individuals with disabilities by promoting inclusion, advocating for their rights, ensuring access to services, and enhancing care quality (Authority for the Care of People with Disabilities, 2024). Understanding practitioner perspectives is crucial, as they mediate how policy is enacted in daily practice for vulnerable learners (Jordan & Stanovich, 2001). Within this context, this study addressed the following research questions:

1. How do SEN practitioners in KSA conceptualize individuals with PIMDs compared with those in other categories of SD or MDs who exhibit low functioning?
2. How do these perspectives inform the services provided for individuals with PIMDs in contemporary SEN practice?

2. Methodology

2.1. Rationale for a Qualitative Approach

To answer the study questions, this study employed an exploratory phenomenological qualitative methodological approach. Rather than simply describing phenomena (Anderson & Arsenault, 2004), this approach organizes and interprets data to generate explanations that deepen understanding and suggest improvements (Gray, 2014). While quantitative surveys could measure the prevalence of certain attitudes, they cannot capture the “why” behind beliefs, practitioner’s conceptual frameworks, or the contexts shaping their views (Anderson & Arsenault, 2004).

2.2. Data Collection

Data were collected through in-depth, semi-structured interviews at the only three CRCs (two of which were merged around August 2025). which provided a consistent framework of questions guided by the research objectives while allowing flexibility to probe emerging themes, follow participants’ train of thought, observe non-verbal cues, and ensure clarity of understanding (Anderson & Arsenault, 2004; Dunwoodie et al., 2023). This method also elicited participants’ views on issues not directly observable by researchers, offering deeper insights into their opinions, values, and lived experiences (Gray, 2014). In addition, it generated information that broadened understanding of the studied issue and expanded the scope of interpretation (Rubin & Rubin, 2012).

The interviews, lasting 60–90 minutes, were conducted in Arabic to enable participants to express themselves with maximum nuance in their native language. With explicit consent, all sessions were audio-recorded, transcribed verbatim, and then translated into English by the bilingual researcher.

2.3. Participant Selection Strategies

This study prioritized qualitative insight over statistical generalization and therefore employed purposive sampling, recruiting specialists who aligned with the research objectives through professional networks and visits to specialist centers. In this sampling method, the number of participants is less important than their relevant characteristics, the type of data sought, and their willingness to contribute (Cohen et al., 2010). Eligibility required SEN specialists with at least one year of direct experience working with girls or women at these CRC centers. A total of 17 participants met these criteria.

2.4. Ethical Considerations

The Scientific Research Ethics Committee of King Saud University approved this study. Moreover, for ethical considerations I followed the 2015 King Saud University Research Ethics Policy in the data collection process, storage, and management of participants' personal information. The study objectives and procedures were explained clearly to all participants to ensure they understood the purpose and significance of their involvement. Participation was entirely voluntary, and individuals were informed that they could decline to answer questions or withdraw from the study at any time, before or during the interview. Participants were also informed that individual interviews would be recorded to ensure the accuracy of the results. To maintain confidentiality, names were replaced with symbols, and the collected information was used solely for the purposes of the current study.

2.5. Data Collection and Analysis Procedure

A data collection tool was developed based on the study questions to guide the interviews, beginning with an opening question and light conversation to reduce participant anxiety. Subsidiary questions allowed topics to be explored in greater depth (Rubin & Rubin, 2012). Interviews were scheduled at appropriate times and durations to accommodate participants' availability, and notes were taken to capture significant statements, prompts for follow-up, unclear responses, and immediate tentative interpretations. At the end of each session, participants were invited to provide additional comments or highlight any overlooked details.

Thematic analysis was employed for data analysis, using participant quotations and manual coding to classify data and identify connections prior to interpretation (Matthews & Ross, 2010). Key texts were revisited iteratively, and patterns were refined to confirm themes and subthemes. Findings emerged from both the description and interpretation of quotations, providing insight into participants' experiences and addressing the research questions (Rubin & Rubin, 2012). The discussion linked the findings to existing literature, highlighting contributions to practice and implications for future research (Braun & Clarke, 2006).

2.6. Trustworthiness

Methodological rigor and trustworthiness were ensured through the criteria of credibility, dependability, transferability, and confirmability (Matthews & Ross, 2010). **Credibility** was strengthened by collecting data directly from specialists, repeatedly reviewing audio recordings, clarifying interview questions when necessary, and discussing interpretations with participants to confirm accuracy. **Dependability** was addressed through pilot interviews that refined the tools and interview techniques, alongside regular methodological review to maintain consistency throughout the data collection process. **Transferability** was supported by purposive and representative sampling, with detailed descriptions of participants and context allowing readers to assess the relevance of findings to other settings. **Confirmability** was achieved by preserving original data through recordings and reflective notes, minimizing researcher bias, and ensuring interpretations were data-driven. Specialists were also given time for reflection, with follow-up communication used to clarify responses where needed. Furthermore, Reflexivity was maintained throughout the research process. The researcher acknowledged that her professional background and prior experience in the field of special education could shape her interpretations. To minimize potential bias, a reflexive journal was kept to document assumptions and reflections during data analysis, and member checking was used to ensure that interpretations remained grounded in participants' perspectives. Moreover, the analysis was guided by established frameworks and studies in disability research, ensuring that interpretations were based on relevant theory and prior evidence rather than personal assumptions. These strategies collectively enhanced the transparency, reflexivity, and trustworthiness of the study.

3. Results and Discussion

Interviews were conducted following a brief tour of the three CRCs during the initial visit, allowing for early observations and the establishment of rapport with participants. The CRCs serve girls and women with SD and PIMDs aged 6–60 years whose families are unable to provide full-time care. Families with children with SD who stay at home can access day care schools for SEN and support services. For families of children with PIMDs who remain at home, the MoHRSD provides financial support and access to facilities, while the Ministry of Health provides additional services. However, not all children attend school, as day care schools often do not accept them.

Each center contains multiple dormitories for girls and women with SD or milder conditions, who participate in community integration projects aimed at returning them to their families. Dormitories are supervised by 2–3 foster mothers, with each assigned a SEN specialist responsible for developing individualized education plans addressing social, independent living, and leisure goals. Centers also provide physical therapy and support from social specialists, psychologists, and leisure activities. Girls and women with PIMDs reside in separate units with dedicated healthcare staff, while receiving individualized support from social specialists, psychologists, and physical therapists, particularly to prevent complications such as bedsores.

To answer the study questions, interviews focused on terminology used by SEN specialists. Questions explored standardized terms for cases at the CRCs, definitions and synonyms of PIMDs, associated characteristics, and required interventions. Results showed variation: some specialists were unaware of PIMD classifications, some described PIMDs using MD or SD, and others applied specific terms as synonyms for PIMDs.

3.1. Theme 1: Conceptual Ambiguity

SEN specialists demonstrated limited familiarity with PIMDs and related classifications. Even when provided a definition, they lacked confidence in addressing follow-up questions. One participant remarked: *"I don't know this exact terminology, but from your description, I think I understand the idea."* Another commented: *"I can give you a book definition, but I don't know the real definition because I've never dealt with this group."* Others noted: *"I sometimes hear composite labels like this, but I'm not sure what they refer to."* Their uncertainty reflects limited direct experience with girls and women with PIMDs, causing specialists to rely on external sources such as academic literature, colleagues, or visitors, even when some PIMD cases were present in the center.

3.2. Theme 2: The Lumping Effect (Conflation of Categories)

A key finding was the lack of a shared, precise definition of PIMDs among SEN specialists, leading to conceptual confusion. Terms such as "multiple" and "severe" were often used interchangeably, leading to students with diverse profiles being grouped into a single "low-functioning" category. One specialist stated, *"all children with multiple disabilities are severe,"* while another commented, *"all multiple in the same boat of a low-functioning."* This stereotyping assumes that multiple disabilities automatically indicate severe functional limitations. Consequently, individuals with multiple mild-to-moderate disabilities may be misclassified as severe, despite differing educational needs.

Internationally, the MD category broadly refers to individuals with more than one disability, ranging from children with mild intellectual disabilities and secondary conditions to those with profound intellectual disabilities and severe additional impairments (Nakken & Vlaskamp, 2007). While the shared factor is the presence of multiple disabilities, the degree and complexity of needs vary widely. This overgeneralization in classification complicates parental access to services, diagnostic clarity, research, service planning, communication about student needs, program development, and resource allocation (Bellamy et al., 2010; Nakken & Vlaskamp, 2007). These findings confirm that terminology does more than describe reality—it shapes it. Nakken and Vlaskamp (2007) emphasize the need to focus on individuals with PIMDs, who have historically been overlooked and treated primarily through a medical lens in non-inclusive care settings.

Locally, the MoE defines MDs in its Organizational Guide for Special Education (2015) as “the presence of more than one disability in a student, such as Intellectual Disability and Deafness or Intellectual Disability and Blindness, which lead to diverse needs that cannot be dealt with through programs designed for one of these disabilities.” From these examples, MDs appear restricted to two co-occurring disabilities; however, the definition remains vague as it does not specify the severity of the disabilities (mild, moderate, or severe). In contrast, the MoHRSD describes the cases under its supervision as including severe physical disabilities (e.g., quadriplegia, cerebral palsy, double amputation), severe intellectual disabilities, and severe dual disabilities (e.g., intellectual disability with blindness or deafness, paralysis with blindness), encompassing PIMDs (Ministry of Human Resources and Social Development, 2025). This distinction shows that MDs and PIMDs are managed separately in terms of both education and services. Since 1992, the

MoE has provided educational support for children with MDs, whereas children with PIMDs primarily receive therapeutic and rehabilitative services from the MoHRSD (Aljaser, 2010). Differentiating students with MDs from those with PIMDs is essential for providing appropriate support: children with MDs often achieve some independence and benefit from programs promoting life skills and participation (Mednick, 2007), whereas children with PIMDs require intensive, individualized interventions focusing on early development, communication, and sensory experiences (Brown et al., 2001; Ouvry & Saunders, 1996). See Table 1.

Table 1. Services in KSA in line with study findings and official documents.

Classification	Multiple Disabilities (MDs)	Severe Disability (SD), such as Severe Intellectual Disability	Profound Intellectual Multiple Disabilities (PIMDs)
Agency	MoE	MoHRSD	MoHRSD
Local Support provides	SEN Teacher (SEN school or integration)	SEN Trainer (Day school care or CRC if parents are unable to take care of them)	CRC
Traditional Label	Educatable	Trainable	Intensive Care Unit

3.3. Theme 3: Recognition Through Classification

Although not explicitly using the term PIMDs, specialists employed specific terminology to distinguish these individuals from other groups within the CRC, using labels such as *untrainable*, *bedridden,* and *intensive care*. For this study, SEN specialists working in the CRC were interviewed in depth to address the following research questions:

1. How do SEN practitioners in KSA conceptualize children with PIMDs in comparison to other categories of SD or MDs who exhibit low functioning?

2. How does this perspective inform the services provided for individuals with PIMDs in contemporary SEN practice?

The interview protocol explored practitioners' perceptions of:

- Learning capacity and educational potential of persons with PIMDs.
- Attitudes toward SEN programs for persons with PIMDs.
- Professional experiences with PIMDs and perceived differences from typical cases.
- Understanding and definitions of PIMDs.
- Goals, challenges, and supports in working with students with PIMDs, including awareness of relevant policies.

Analysis revealed two major themes: Recognition of PIMDs through Deficit Terminology and Recognition of PIMDs through Valuing and Rights.

3.3.1. Recognition of PIMDs through Deficit Terminology

Most SEN specialists focused on children's limitations and impairments, reflected in the following sub-themes:

3.3.1.1. Functional Dependency

This theme emphasizes dependence on others for basic life functions. This is illustrated by the statements: *"They have very high needs and total absence of functional skills," "They are the most vulnerable group with daily care needs including feeding, changing, positioning,"* "*They are fully dependent on everything,"* and "*Classification doesn't matter…they need the highest support and constant adult presence."* Such language frames girls and women with PIMDs solely in terms of dependency, overshadowing social presence and individuality, and highlighting how this perspective can undermine formal classification systems.

3.3.1.2. Fear and Risk Aversion

The central idea of this theme is the fear and reluctance of practitioners to interact directly. Practitioners expressed statements such as: "*They are ill and I am afraid of contacting them,*" *"I feel nervous working with ICU girls because I'm not sure what they might do,*" and *"Their immunity is very low and I am worried about* *getting an infection."* These quotes reveal a stereotypical view of girls and women with PIMDs as fragile medical cases, leading to avoidance and depriving them of essential social and emotional stimulation needed for growth and quality of life.

3.3.1.3. Behaviors as Barriers to Interaction

This theme captures how certain behaviors were perceived as obstacles to engagement. For instance, one practitioner noted: *"They refuse us and scream when we try to play with them…some don't have contact at all…so I don't know how I work with them."* Another explained: *"They are all the time lying with no contact at all, unresponsive and reclusive, which ends interaction."* Others noted: *"Their tantrums are disruptive and refuse to play...they don't really know what we are doing.*" These quotes highlight behaviors such as hyperactivity (screaming, agitation, excessive vocalization) and minimal overt behavior, which were seen as preventing genuine engagement. Yet, they may reflect meaningful communication or unmet needs. Recognizing these behaviors as communicative opens opportunities for responsive, supportive, and engaging interactions, shifting the focus from limitations to potential.

3.3.1.4. Pity and Charity Lens

This theme reflects the perspective of some specialists who framed girls and women with PIMDs as primarily suffering and merely in need of daily care. One practitioner said: *"It breaks my heart to see them…they deserve care and someone to look after their daily needs."* Another said: *"These girls can't do anything…we need to make their lives as comfortable as possible."* Others noted: *"Their presence reminds us to be grateful…they deserve our care"* and *"These poor souls need someone to look after them."* Such statements reflect emotional labor framed by tragedy, portraying girls and women with PIMDs as burdens rather than acknowledging their dignity, humanity, and potential for meaningful experiences when provided appropriate support.

3.3.1.5. Over-medicalization of Disability

This theme reflects the tendency to define girls and women with PIMDs primarily by their health conditions. One practitioner noted:

"These girls need health support; my interventions seem useless." Another stated: *"They are bedridden cases under medical supervision," adding, "I have nothing to do with them, even if they are disabled; they need health care."* Such perspectives reduce girls and women with PIMDs to patients, overlooking their potential for meaningful experiences and failing to recognize them as whole persons beyond their medical needs.

3.3.1.6. Family Tragic and Burdensome Narrative

This theme highlights the perceived burden on families. One specialist remarked: *"Most girls in the medical section spend their time in the center because their families are not capable of providing the care needed."* Another added: "*We succeed in moving some with their family, but for cases of ICU, staying in the center is good for them…give the girls a safe place for both the child and the family."* Another practitioner explained: *"Caregiving can feel like a life sentence, placing heavy strain on parents and affecting the child and the family."* This framing portrays family life as tragic, reducing parental involvement to relief provision rather than meaningful engagement, while overlooking the family's critical role as the child's main source of love, belonging, and identity.

3.3.1.7. Overprotection and Restrictive Environments

This theme reflects a protectionist approach. One practitioner said: *"The best environment is kept safe and cared for."* Another expressed concern by saying: *"We take them under their health staff supervision outside the room, but without having another group with them…*children with less severe disabilities may *do unsuitable things that harm them, like giving them solid food."* While intended to ensure safety, these perspectives create isolation, limiting opportunities for meaningful interaction, social engagement, and skill development that could be fostered in a carefully monitored, inclusive setting.

3.3.1.8. Low Expectations and Incapacity to Learn

This theme reflects the stereotype of incapability in learning. One practitioner highlighted this by stating: *"They don't understand* *what's going on...there's nothing to measure."* Another remarked: "*They are too disabled…when I contact them, they don't respond."* A third added: *"They are completely unaware of their surroundings; there's no point setting a goal."* These statements reveal the belief that conventional developmental benchmarks determine learning potential, overlooking subtle forms of communication such as gaze shifts, tolerance to stimuli, or relaxation to a calm voice. Lack of overt verbal or motor responses is often misinterpreted as the absence of learning potential.

3.3.1.9. Caretaking Rather Than Learning and Development

This theme builds on the previous one, showing that assumptions of limited learning capacity shift practitioners' roles toward caretaking, reinforcing educational exclusion. One practitioner remarked: *"I focus on cases where progress is realistic…They are bedridden; my interventions are useless."* Another said: *"We visit once a week without a plan; we just talk and play."* Some framed certain students as outside their role: "*They need care, not interventions,"* and "*We don't accept ICU girls in our workshops; visiting their rooms is a personal effort.*" Others prioritized "trainable" students: *"For untrainable students, setting learning goals is a waste of time. The ministry wants trainable students returned to families, so that's where I focus…sometimes if their health allows taking them out briefly with medical staff or using YouTube."* One practitioner explained: "*We had an obese patient whose movement improved and she lost weight after medical transfer."*

These quotations illustrate that, despite all students with disabilities being part of SEN support, specialists often view girls and women with PIMDs solely in terms of medical needs, excluding them from structured developmental SEN programs addressing communication, social, emotional, interaction, or sensory learning. The last quotation particularly illustrates that when a student requires health support, formal SEN interventions are often considered impossible. Even when interaction occurs, it is informal and unstructured, described as personal effort rather than an official developmental plan. The presence of students with mild intellectual disabilities—admitted due to lack of family care—diverts attention from girls and women with PIMDs. Activities such as occasional outings to their rooms or watching YouTube, while providing some sensory stimulation, remain passive and fail to meaningfully engage the child or reflect their preferences.

3.3.1.10. Excluding from Mainstream Environments

The central idea of this theme is the belief that isolation provides the most appropriate environment. One practitioner said: *"Integration in class in a mainstream school is not realistic for these cases; the best environment is in shelters that provide protection and comfort and meet their basic needs."* Others agreed, calling it *"not practical"* or asking *"what benefit would there be for bedridden children?"* Another noted: "*They won't be part of the wider mainstream school community."* Safety was also cited: *"A mainstream school simply isn't equipped to handle a potential medical emergency…it's a fundamental safety issue."* While these statements reflect concern for safety, they risk justifying exclusion by implying that girls and women with PIMDs do not belong in mainstream settings. Social integration with typically developing peers can foster communication, engagement, and skill development. With peer support and small-group activities, schools can ensure safety while promoting relationships and a sense of belonging.

3.3.2. Recognition PIMDs through Valuing and Rights

Few SEN specialists express this perspective. Their responses suggest that barriers arise more from structural constraints than from the children's impairments, highlighting the recognition and celebration of disability alongside the promotion of children's rights. This is reflected in the following sub-themes:

3.2.2.1. Barriers and Exclusion

The core principle of this theme is that environmental barriers, rather than inherent limitations, restrict participation. One specialist observed: *"What I feared wasn't their disability, but the isolation created…the rooms are not prepared for their needs."* Others highlighted assumptions that create barriers: *"The feeling of anxiety working with ICU cases is about our assumptions, not about the girl…patience is necessary…they need continuous joyful interaction* *until they show their first attempt. I am against total dependence on nurses. They bother me when they scare us...Let's get away from fear."* These reflections emphasize that environmental conditions and societal attitudes can limit children's opportunities, causing exclusion, inactivity, and disengagement. The findings underscore the need to transform physical spaces and staff attitudes rather than focusing solely on impairment.

3.3.2.2. Valuing and Identity

This theme centers on recognizing worth and identity beyond medical needs. One specialist remarked: *"It saddens me to see rooms dominated by medical equipment…they need sun, gardens, and activities like sensory or doll games."* Another noted: *"You must be patient and see beyond the usual; with time, results will appear."* A third specialist shared: *"When one of my girls moved to the medical ward, I sensed her longing for me and saw a major setback."*

Specialists emphasized the importance of moving beyond deficit-focused thinking to create stimulating, joyful environments—filled with sensory games, nature, and fun activities—challenging the sterile, fear-driven atmosphere of rooms dominated by medical equipment while maintaining stable routines to support children's emotional well-being. They stressed the value of patiently focusing on cases beyond the usual reflection, encouraging long-term engagement, fostering growth, and recognizing the unique abilities and potential of each girl/woman with PIMDs. The last quotation underscores how disruptions to established connections and routines can profoundly affect a child's sense of self, reinforcing the value of stable, meaningful relationships.

3.3.2.3. Equality and Entitlements

This theme emphasizes that support for girls/women with PIMDs is a fundamental human right rather than an optional service. One specialist reflected on changes in practice: *"Before, we were encouraged to engage with all cases, even those who only moved their eyelashes. Now the focus is on less severe cases, and the ICUs are often ignored…they have the right to enjoy life and be part of a* *community."* Another emphasized: *"Everywhere I go, I demand and explain my point of view. We see them daily and know the situation is dire. It's not their fault they are bedridden—they should have the chance to interact and enjoy their day, not only with the same cases."* The specialists' comments highlight that girls/women with PIMDs are entitled to meaningful engagement, not solely medical care. They advocate for caregivers and professionals to proactively create opportunities for interaction, play, and participation, stressing the ethical responsibility to remove barriers while recognizing that being bedridden is not the child's fault.

4. Discussion

The challenges extend beyond misunderstandings of PIMDs, as most SEN specialists, though familiar with the terminology, continue to rely on traditional approaches. Recognition of PIMDs remains influenced by the Charitable Model (CM) and Medical Model (MM), which marginalize this group in SEN practice. The CM, the oldest model, positions disabled individuals as objects of pity and benevolence, where access to resources depends on generosity rather than entitlement (Oliver, 1996; Shakespeare, 2006). Practitioners' language, such as "poor souls," "care," "comfort," or "the best environment is in shelters," reflects a benevolent but patronizing perspective, reinforcing segregation and framing institutional support as sympathetic charity. Within this framework, SEN support is considered optional, reduced to "personal effort" rather than professional responsibility. Fear of contact—expressed as "I am afraid of contacting them"—leads to overprotective practices that further isolate these students and limit engagement. Moreover, families are similarly depicted as overburdened, facing a "life sentence," with institutional support framed as charity rather than a shared, rights-based responsibility.

The MM, in contrast, views disability as an individual problem located within the body, framing it as an impairment requiring cure or medical management (Oliver, 1996; Shakespeare, 2006). For example, a child "cannot read that magazine because they cannot see" or "cannot go to school due to a physical deficit." This perspective equates impairment with disability, reducing the latter solely to functional limitations of the body or mind (Shakespeare, 2006). Within this perspective, PIMDs are described as "bedridden," "under medical supervision," or in the "Intensive Care Unit," leading practitioners to conclude that SEN interventions are "useless." Fragile health is used to justify exclusion from learning and social interaction, while statements such as "there's nothing to measure" reflect low expectations that prioritize caretaking over learning and development. Behaviors such as refusal, screaming, or being "unresponsive and reclusive" are interpreted as barriers or signs of pathology rather than as meaningful forms of communication. Table 2 summarizes how different models conceptualize disability, the services they emphasize, and the resulting educational approaches.

Table 2. Comparing definitions and services across models.

	The Focus	**The Services**	**Disability Reason**	**Education**
The Charitable Model	The suffering faced by individuals with disabilities	Pity, caring, and protection	A personal tragedy or misfortune	Nothing
The Medical Model	The difficulties faced by individuals with disabilities	Medical services	The person with a disability is the problem; because of the impairments. Where the person must be "fixed" to fit into society.	Nothing
The Psychological Model	The difficulties faced by individuals with disabilities	Therapy, adjustment, and coping strategies to enhance personal functioning	Disability is seen as the individual's problem, requiring therapy or intervention to adapt to societal norms	Special separated schools
The Social Model	The obstacles created by society	Multiple, aiming to modify the conditions of society	Any physical or tangible obstacle	Integration
The Affirmation Model	How disabled persons see themselves	Strength-based and self-determination	Stereotypical thinking, attitudes that reject change, and acceptance of difference	Inclusive education

Both models ultimately reduce girls and women with PIMDs to either recipients of care or subjects of medical surveillance, denying them access to SEN support, community belonging, and active participation. This highlights the need to establish a definition of PIMDs grounded in the Social Model (SM), the Rights-Based Model (RBM), and the Affirmation Model (AM), encouraging a move away from traditional perspectives toward a more contemporary understanding of disability. The SM, developed in the 20th century in response to disability rights movements, rejects the MM while recognizing the need for medical treatment for PIMDs to support growth, prevent malnutrition, and provide respiratory care. It shifts attention from impairments to societal barriers that restrict full participation, emphasizing environmental change rather than changing the child (Oliver, 1996; Shakespeare, 2006). Disability is thus defined not as impairment, as in the MM, but as the disadvantage created by inaccessible buildings, negative attitudes, insufficient support, or exclusionary policies. Few SEN specialists viewed the challenges faced by girls/women with PIMDs as solely caused by their conditions; instead, difficulties were often linked to environments lacking communication support, accessible learning opportunities, or peer interactions. For example, rather than viewing behaviors as inherently problematic, the SM perspective interprets them as meaningful responses to inaccessible environments, as reflected in comments such as, “What I feared wasn’t the child’s disability, but the isolation created,” and, “It is about our assumptions, not about the child.” Poppes et al. (2016) found staff often regarded challenging behaviors such as self-injury, stereotypy, and aggression as minor, attributing them primarily to medical or physical causes, reflecting partial preference for the biomedical model. Yet overall, staff generally found no single model fully explanatory. Similarly, Nijs et al. (2016) confirmed that for PIMDs, challenging behaviors often reflect sensory environment overload and limited autonomy rather than inherent pathology. Munde and Vlaskamp (2009) further emphasized that environmental factors—including interaction quality, stimulation, and communication—significantly influence alertness and emotional expression. These behaviors should therefore be seen as expressions of distress or communication attempts, not dismissed as meaningless. Table 3 compares how different models conceptualize impairment and disability, highlighting the distinct assumptions and implications of each approach .

Table 3. Comparing definitions of impairment and disability across models.

	Impairment	**Disability**	**Correlation**
The Medical Model	Impairment refers to a physical, mental, or sensory limitation of the body or mind.	Disability is caused by the impairment.	The medical model views the terms "disability" and "deficit" as synonymous, and uses them to describe the "medical" condition that a person is said to suffer from.
The Social Model	Impairment refers to a physical, mental, or sensory limitation of the body or mind.	Disability is the restriction imposed by society, including attitudes, policies, and social structures.	Disability results from the interaction of impairment and societal barriers, not from the impairment itself. Removing obstacles such as inaccessibility or negative attitudes enables participation and independence.
The Affirmation Model	Impairment is a variation and difference of body or mind, not inherently negative.	Disability is a difference that can be affirming, part of human diversity.	This contrasts with the medical model, which sees impairment as a deficit, and the social model, which may overlook the lived reality of impairment by focusing only on societal barriers.

The holistic approach reflects the SM by addressing social, educational, and emotional barriers beyond medical care, as illustrated in the statement: "I am against total dependence on nurses." Peltomäki (2021) shows that collaborative IEP goal-setting with teachers, therapists, and parents leads to more effective outcomes. Zijlstra and Vlaskamp (2005) argue that waiting for children to "feel well" is inefficient, as prolonged absence risks under-stimulation, making coordinated multidisciplinary involvement essential. Vlaskamp et al. (2009) emphasize that integrated collaboration among educational, therapeutic, and medical professionals enhances development and quality of life. For instance, physical therapy may cause discomfort, but creative, classroom-based approaches designed jointly by therapists and SEN teachers can better support the child (Aljaser, 2010).

The AM, emerging in the late 21st century, extends the SM by not only removing barriers but also celebrating impairment as a positive form of identity and human diversity (Cameron, 2014; Swain & French, 2000), rejecting the notion that disability is something to be pitied or cured (Swain & French, 2000). Unlike the SM, which focuses primarily on societal obstacles, the AM emphasizes that disabled individuals can enjoy life while embracing impairment as part of their identity (see Table 3). This perspective highlights the value of diverse communication in children with PIMDs, encouraging practitioners to see worth beyond "normal" expectations. Farmer and Stringer (2023) and Grove et al. (1999) demonstrate that non-verbal children possess agency, with adults interpreting cues to support meaningful participation. Gjermestad et al. (2022) and Ware (2004) further emphasize gestures, facial expressions, and reactions as valid forms of communication, while Skarsaune (2022) shows that children with PIMDs can engage in self-determination affecting their lives when appropriately supported. Similarly, Arthur-Kelly et al. (2008) confirm that behavior is the primary mode of communication and engagement for students with PIMD, and that careful observation and interpretation of these behaviors are essential for fostering inclusion and meaningful participation. In addition, rather than viewing girls/women with PIMDs as a burden, the AM affirms their lives as meaningful. For example, one child said, "I want a program of fun rooms and outdoor activities." Penninga et al. (2022) found that staff experienced moments of interaction as deeply meaningful when children responded or initiated contact, benefiting both the child and the caregiver's sense of purpose and impact.

Finally, the RBM frames inclusion as a non-negotiable entitlement, establishing accountability to ensure rights are upheld (Degener, 2016, 2017). It positions girls/women with PIMDs as rights-holders, not dependents, making access to SEN and participation a matter of justice rather than charity. Quotations such as "They have the right to enjoy" and "the right to be part of a community" highlight this principle. This model rejects segregation, emphasizing full societal inclusion. Aljaser (2010) reported that, under the Equality Act, many children previously confined at home or in hospitals now attend special or mainstream schools, with separate classrooms where social interaction enhances development and reduces stigma. For instance, a child with PIMDs showed joy and increased hand movements when a mainstream peer joined the special class during mealtime. Similarly, Haakma et al. (2021) and Simmons (2021) found that mainstream environments, even with limited interaction, foster belonging, social presence, and shared experiences .

Together, the SM, AM, and RBM counter the CM and MM by reframing PIMDs not as burdens or medical problems, but as expressions of human diversity to be recognized and celebrated.

5. Conclusion and Recommendations

This study highlights a critical gap in the conceptualization and service provision for individuals with PIMDs within the KSA SEN context. Findings indicate that, while SEN practitioners are familiar with the terminology surrounding PIMDs, their understanding is largely rooted in traditional frameworks, particularly the CM and MM. These models marginalize individuals with PIMDs by framing them as care recipients or subjects of medical oversight, rather than as active participants in the center.. The reliance on such models contributes to the persistence of limited service provision and reinforces barriers to educational participation, and personal development for this population.

The findings underscore the need to adopt contemporary frameworks—the SM, RBM, and AM—that emphasize the personhood, agency, and potential of individuals with PIMDs. Grounding PIMD conceptualization in these progressive models can improve the quality, relevance, and inclusivity of SEN services in KSA.

Further research on PIMDs in KSA is recommended, particularly studies grounded in Disability Studies, to explore contemporary approaches in real-world settings and inform evidence-based policy and service delivery. Moreover, although this study focuses on the KSA context to address the current knowledge gap, it offers insights that may benefit similar contexts and serve as a foundation for broader future studies or cross-cultural comparisons.

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