# Exam Preparation

**Learning Goals**

- Demonstrate knowledge of concepts of disability and impairment
- Understand international, national and community perceptions of disability
- Explore the experience of individuals living with a disability, their families and carers
- Demonstrate knowledge and breadth of the disability service delivery system and the principles and practice framework required for professional practice

## Lecture 1 - Introduction

Lecture 1 - Introduction

▼ **Summary**

**Statistics**

- Around 18% of the population have a disability (1 in 5)
- Disability may affect a person's mobility, communication or learning. It can affect their income, education, social activities and the labour force

**Disability in SWHS**

- 50% of people in prison have a disability
- Strong association between acquired brain injury and homelessness
- 90% of women with a disability are likely to be sexually assaulted

**United Nations Convention of the Rights of Persons with Disabilities (2006)**

- The purpose of the present convention is to promote, protect & ensure the full & equal enjoyment of all human rights & fundamental freedoms by all persons with disabilities
- Promote respect for inherent dignity

**Disability/Impairment**

- Disability is the loss or limitation of opportunities to take part in the normal life of the community to an equal level with others, due to physical and social barriers which are socially produced
- Disabled People International (DPI) defines disability in social terms and as an inherent consequence of societal factors (Mallet & Runswick-Cole, 2014). The DPI offers a clear distinction between impairment and disability; impairment is the functional limitation caused by physical, mental or sensory impairment, whilst disability is defined as the loss or limitation of opportunities to contribute to society on an equal level due to physical and social barriers (Mallet & Runswick-Cole, 2014).

**Stereotypes**

- Stereotypes are shared generalizations held about members of particular social groups
- Stereotypes are very slow and difficult to change, and when it does it generally occurs in response to social-political and economical changes - also become more marked and hostile when social tension/conflict arises between groups
- Stereotypes may emerge to justify actions that have been committed or planned by one group against another group; if one group exploits another group it may be useful to justify this action by developing a stereotype of the outgroup as unsophisticated and dependent

**Prejudice**

- Prejudice refers to the attitudes and feelings, whether positive or negative and whether conscious or non-conscious, that people have about members of other groups
- Unfavourable attitude towards a social group and its members
- A Traditional view of Prejudice comprises three components (Allport, 1954)
    1. Cognitive – set of belief about social group
    2. Affective – strong feeling about the group and their qualities
    3. Conative - set of intentions to act in a set way toward the social group

**Ableism**

- Ableism is a prejudice that preferences “normative” standardised body form while subjugating non-normative bodies
- It is a set of belief, processes and practices about the kind of body that holds value and worth
- Ableist thinking and systems, have led to the re-produced idea of the ‘typical’ self and body that personifies being human

**Stigma**

- Exploitation and domination – (keeping people down)
- Social norm enforcement - (keeping people in)
- Disease avoidance - (keeping people away)
- Stigma involves reaction to perceived negative deviance
- Four types of stigma model:
  - Public stigma: Consensual understanding that a social attribute is devalued - social/psychological reaction to someone perceives as having stigmatized condition
  - Self Stigma: Social and psychological impact of possessing
  - Stigma Stigma by association: Social/psychological reaction to people associate with a stigmatized person
  - Structural Stigma: Legitimatizing and perpetuation of stigmatized status by society’s institution and ideological systems

## Lecture 2 - Critical Disability Theory

Lecture 2 - Historical Context & Critical Disability Theory

▼ **Summary**

**Medical Model & Individualisation of Disability**

- Under the normative gaze of medicalisation, disability is largely seen as in terms of individualised problems of biological and psychological processes, rather than social issues (Goodley, 2014)
- The individual is viewed as the biological/physiological (Impairment, Medicine, Therapy, Pain)

- Treatment and perception of persons with disability - Historically dehumanised, demonised and expelled

**Institutionalisation of People With Disabilities**

- Types of institutions throughout Australia Chenoweth (2000)
    - Large states run settings, such as and Basil Stafford in Queensland
    - Charitable organisation run settings
    - This was mirrored in other parts of the western world.

**De-Institutionalisation to Community Living**

- As part of the Participatory Democracy Movement (1960) in the UK and US, political activism for de-institutionalisation commenced → Australia was 20 years behind and began in 1980

**Social Role Valorisation**

- Wolfensberger (1992) in US – interested in what society saw as the "good life", and how particular people  with certain attributes were denied this
- Wolfensberger's cultural tenet:
    - Human perception is not value free – we evaluate all the time
    - People most likely to be devalued in Western societies are people who are 'impaired or handicapped'; who are 'seriously disordered in their conduct or behaviour'; those who 'rebel against the social orsder'; the poor; people who have few or unwanted skills; and finally others who are unassimilated into the culture for other reasons (for example, the elderly, the unborn, racial and ethnic minorities).
- Deviancy Roles

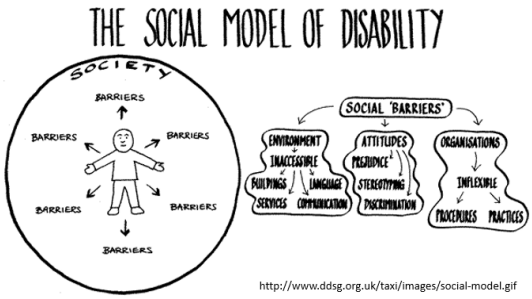
**Wolfensberger's wounds – wounding and the Deviancy Roles**

- **Other** – the person with a disability marginalised as other to the dominant social group;
- **Non-human** – to be regarded as either sub-human, animal, vegetable or object;
- **Menace** – to be regarded as a threat to be feared, an annoyance or an object of dread;
- **Object of Ridicule** – to be regarded as a something to be made fun of or as trivial; freak
- **Object of Pity** – to be regarded as a tragic victim;
- **Burden of Charity** – to be regarded as a drain on the goodwill of others or the public purse;
- **Diseased Organism** – that is, as sick; sick role
- **Child** – to be regarded as either perpetually a child (in the case of people with intellectual disability) or as returning to childhood (the elderly or people with acquired brain injuries); and
- Dead or Dying – to be regarded as better off dead, nearly dead or as already dead

(adapted from Wolfensberger, 1992: 10-12).

## Social Model of Disability

- The rejection of the medical model approach
- Challenges the individualised approaches
- Value the direct experience and understanding of disability by disabled people themselves
- Addressing issues of marginalisation, oppression and discrimination "othering"
- Identifying and removing disabling barriers produced by social and cultural institutions that prevent people for full inclusion and participation



http://www.ddsg.org.uk/taxi/images/social-model.gif

## International Classification of Functioning, Disability, and Health (ICF) - World Health Organisation

- A universal model – for all people, not just people with disabilities
- A holistic model - focuses on the whole person + their environment
- A strengths-based model – highlights what people can do! An interactive model – shows the interaction between a person + their environment