People with Disabilities and Social Work: Historical and Contemporary Issues
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From the earliest recorded history, people with disabilities have been ostracized, rejected, and discriminated against in society. Although social work has a history rich in advocacy for oppressed people, the profession has been hesitant to become involved with people with disabilities. This article addresses historical and contemporary issues concerning disability. Recent developments in the disability movement, including independent living, are discussed and compared to social work's approaches to disability. Finally, a plea is made to the social work profession and the disability movement to combine efforts to enhance the lives of people with disabilities.

Key words: disability; disability movement; independent living; minority model; strengths perspective

The Americans with Disabilities Act (ADA) of 1990 (P.L. 101-336) was a civil rights landmark for people with disabilities. With the passage of the ADA, Congress acknowledged that the 43,000,000 Americans with disabilities have been subjected to serious and pervasive discrimination. Congress also acknowledged that unlike other populations who have experienced discrimination, people with disabilities have had "no legal recourse to redress such discrimination." From the beginning, social work has viewed itself as the profession with primary responsibility toward people who are subjected to discrimination and oppression. However, the profession has not embraced the causes of people with disabilities as it has other oppressed groups. Consequently, relatively few social workers work with people with disabilities, few people with disabilities enter the profession, and the profession has done little to promote disability rights (Mackelprang, 1993; Mackelprang & Santos, 1992).

This article examines the history of societal values and attitudes about people with disabilities and the rise of the disability movement. Social work and independent living approaches to working with people with disabilities are compared and contrasted, and suggestions for integrating both approaches are provided. Finally, a plea is made for social work to re-evaluate its commitment to people with disabilities.

History of Treatment of People with Disabilities
Throughout the history of humankind people with disabilities have been a part of society; archaeologists have repeatedly uncovered evidence of people with disabilities dating as far back as the Neanderthal Period. Societies treated and responded to people with disabilities based on their cultural belief systems.

Ancient Beliefs
Neolithic tribes perceived people with disabilities as possessed by spirits. When the spirits were perceived as evil, escape routes were fashioned by drilling holes in the skulls of people who were
thought to be possessed (Albrecht, 1992). The Spartans, with their rugged individualism, abandoned young and old people with disabilities in the countryside to die. Plato (1991), to whom Western culture owes much of its ethical framework, viewed people with disabilities as standing in the way of a perfect world: “the offspring of the inferior, or of the better when they chance to be deformed, will be put away in some mysterious, unknown place, as they should be” (p. 183). The Romans, who borrowed the concept of reciprocity from the Greeks, gave assistance to adult people with disabilities with the expectation that they would demonstrate thanks by not rioting. However, like the Greeks the Romans also abandoned disabled or deformed children to die (Morris, 1986).

**Judeo-Christian Beliefs**

Judeo-Christian tradition, prevalent among Europeans during and after the Middle Ages, taught that people with disabilities were expressions of God’s displeasure (Livneh, 1982). Although Judeo-Christian philosophy did not advocate killing, people with disabilities were ostracized and stereotyped. Disability signified “sinner” to the ancient Hebrews, and people with disabilities were thought to be possessed by evil demons. People who were deformed, “crippled,” or of short stature were forbidden to become priests. The Old Testament forbade people who were blind or lame from entering the houses of believers (Wright, 1960). In the New Testament, people with mental disorders were believed to be possessed. It was thought that people with disabilities had them because of their own or their parents’ sins. Treatment centered on spiritual redemption (Albrecht, 1992).

Judeo-Christian thought, on which much of Western culture is based, has also taught that humans are made in God’s image and are different from and superior to the rest of the animal kingdom. Livneh (1980) contended that people with disabilities remind those without disabilities of their own or their parents’ sins. Livneh (1982) believed that the segregation of people with disabilities decreases the chances of association, allowing people to deny the eventual loss of physical integrity and ultimately death. Livneh also contended that people with disabilities threaten those without disabilities with the knowledge that their limber walk, strong muscles, and sexual prowess are temporary.

**17th-Century Beliefs**

The rise of capitalism during the Industrial Era presented unprecedented labor needs and social problems. With the codification of the Elizabethan Poor Laws in 1601, England endeavored to deal with the dilemma of caring for needy people while maintaining a labor force for its developing industries. Stone (1984) suggested that the Poor Laws were England’s attempt to reconcile this dilemma by creating a “system of categorical exemption” (p. 51) by classifying poor people into deserving and non-deserving categories. Orphaned, blind, and “crippled” people were deemed deserving and received charity less begrudgingly than so-called non-deserving poor people.

**18th-Century Beliefs**

By the mid-1770s, a new perspective on the human situation, the Enlightenment, was making its impact on Europeans and Americans. Out of the tenets of the era came the idea that perhaps humans could be perfected. Within this environment, a model of treatment began to emerge that defined people with disabilities by their biological inadequacies. In the United States, institutions dedicated to perfecting the imperfect sprang up (Rothman, 1971) with the hope that professional intervention could cure these inadequacies. When a cure was not possible, people with disabilities could at least be trained to become functional enough to “perform socially or vocationally in an acceptable manner” (Longmore, 1987b, p. 355).

**19th-Century Beliefs**

The 1800s began with the continuing belief that humans could change. Professionals held great hope that “deviants,” which included people with disabilities, could be molded into assimilated, less threatening, more acceptable people (Rothman, 1971).

However, by the end of the 19th century, the ominous philosophy of social Darwinism and eugenics came to prominence. Deutsch (1949)
quoted Darwin's cousin Frances Faltin, who described eugenics as "the study of the agencies under social control that may improve or impair the racial qualities of future generations either physically or mentally" (p. 358). Rhodes (1993) concluded, "the movement emphasized the dominance of heredity and sought to encourage the reproduction of socially desirable individuals (positive eugenics) and discourage the reproduction of the undesirable (negative eugenics)" (p. 6).

Eugenics became a convenient explanation for the ills of society and cast people with disabilities in a frightening light, making them extremely vulnerable. Professionals lost confidence in their ability to perfect people with disabilities, concluding that they were innately unproductive and thus endemically without worth. No intervention could bring about change because the laws of nature deemed people with disabilities unfit (Longmore, 1987a). People with disabilities were to be prevented from marrying or having children for fear of propagating their imperfections. As the 19th century progressed, institutions to deal with the threat and nuisance of people with disabilities increased dramatically, and they were increasingly isolated and institutionalized, sometimes in subhuman conditions.

20th-Century Beliefs

Early 20th-century America offered little attitudinal progress. People with disabilities were objects of shame and disgrace. Parents, often on the advice of professionals, hid disabled children from society in their homes or in institutions. Gallagher (1985) recounted the prevailing attitudes of the time in the experiences of President Franklin D. Roosevelt as a person with a disability. Roosevelt was continually forced to compensate for society's attitudes and to hide his disability from the public.

World War I and World War II marked superficial advancement for people with disabilities. Federal rehabilitation legislation produced money for treatment of veterans disabled by war. However, the stereotype of people with disabilities as nonproductive and socially abject was prominent through the 1950s (Longmore, 1987b). During the second half of the 20th century the ideas of past eras continued to influence professional practice.

Mental health practice has focused on individual weakness and pathology. The DSM-IV (American Psychological Association, 1994), the major diagnostic tool of mental health practitioners, is devoted to the diagnosis of pathology, with almost no attention given to strengths. Similarly, medical evaluations measure pathology and the lack of pathology but rarely measure strengths. Diagnoses within these settings also focus exclusively on the individuals being diagnosed, neglecting social, environmental, and contextual factors that influence people's situations.

The medical model views physicians as treatment directors and nurses, therapists, social workers, and other health care professionals as assistants who help direct patients' lives. Patients are passive recipients of treatments that are dispensed by professionals who are experts. The experts make the decisions and inform patients of those decisions (Trieschmann, 1980). If people with disabilities who use professional services attempt to become active consumers and control their care, they become vulnerable to the withdrawal of help from providers who do not like having their authority questioned. This dependence forced on people with disabilities by professionals and society as a whole has led to great dissatisfaction. Thus, in the last decade of the 20th century, people with disabilities have demanded the right to take control of their lives.

Independent Living and the Minority Model

The birth of disability consciousness in the United States arose out of the turbulence of the 1960s, a decade of re-examination, challenge, analysis, and change. For the first time in U.S. history, perhaps even in Western history, significant numbers of people with disabilities demanded access to the mainstream of society.

The disability movement matured with the development of the independent living concept in the early 1970s. Initially led by people such as Lex Mackelprang and Salsgiver / People with Disabilities and Social Work: Historical and Contemporary Issues
Frieden, Judy Heumann, and Ed Roberts, independent living applied the minority model as the foundation of the political process of gaining the civil rights of people with disabilities (Berkowitz, 1987). Whereas traditional Judeo-Christian culture and traditional models of professional treatment focused on individual pathology (Weick, Rapp, Sullivan, & Kisthardt, 1989), independent living focused on societal responses and discrimination as the primary barriers to civil rights.

The independent living perspective views people with disabilities not as patients or clients but as active and responsible consumers. Independent living proponents reject traditional treatment approaches as offensive and disenfranchising and demand control over their own lives. For example, when people with physical disabilities have needed physical assistance with self-care, that care is primarily provided by licensed professionals assigned through formal agencies. In contrast, independent living proponents retain their own personal responsibility to hire and fire people who provide attendant care. They eschew the need for licensed providers such as registered nurses to provide care, favoring instead attendants who are trained by the individuals with disabilities themselves. Social workers become involved with these individuals only by request.

Traditional medical paradigms define the nature of disability by individual deficiencies and biology. For example, justifications for keeping children with disabilities out of regular public schools have centered on their impairments. Proponents of independent living contend that children with disabilities have not been allowed to attend regular schools because of physical, attitudinal, and legal barriers and not because of individual incapabilities. As a group—as a minority—these children have been denied their right to education (Meyerson, 1988).

The minority model asserts that discrimination against people with disabilities is rooted in the beliefs and values of the culture. The most fundamental belief is that people with disabilities cannot and should not work or otherwise be productive. For example, Stone (1984) stressed that residual benefits of the Elizabethan Poor Laws are the ensured support and services to people with disabilities in the current welfare state. What Stone and others failed to recognize is that categorizing people with disabilities as deserving of charity creates a dubious benefit wherein they qualify for an ever-eroding baseline of services and are relegated to subsistence-level living. At the same time, the social welfare system creates pervasive disincentives to work and reinforces the idea that people with disabilities do not need to work. For example, if people receiving Social Security Disability and Medicare return to work, they will lose not only their payments but also their medical coverage, which would be financially devastating and potentially life threatening. The minority model views the lack of work options as repressive and decries this discrimination.

Contributing to the belief that people with disabilities should not work is the role of sick people in Western culture. People with disabilities, whom society assumes are "sick," are expected to fill this role even when they are perfectly healthy. As with those who are sick, people with disabilities are to be taken care of and to be provided for. Their only obligation is to be grateful for the help given them (Devore & Schlesinger, 1987), thus subjecting them to a form of benevolent oppression.

When the expectations that people with disabilities should not work and should fulfill the sick role are foisted on people for their lifetimes, they invariably believe those messages and act accordingly. Also, people with disabilities have been given few opportunities to develop skills associated with independence and self-sufficiency. Attributions of personal unworthiness based on spiritual beliefs further promulgate oppression and isolation.

The behavior, self-concept, educational achievement, and economic success of people with disabilities can be understood only by viewing people with disabilities as a minority group who are subjected to discrimination found in their social environments (Fine & Asch, 1988). Independent living encourages people with disabilities to begin to assert their capabilities personally and in the political arena.

Social Work, Independent Living, and Disability

Social work philosophy shares many similarities with the minority model of viewing people and their environments. Social workers use a systems perspective, acknowledging the influences of the environment on personal functioning. However, the person-in-environment perspective differs from independent living in that it maintains a heavy emphasis on Freudian and neo-Freudian
philosophy (Hepworth & Larsen, 1993). With the emergence and expansion of other trends of thought in recent decades, the importance of systems, culture, and social supports has become increasingly emphasized. Ecological systems theory has been a natural outgrowth and synthesis of these trends (Hepworth & Larsen, 1993).

As social work matured from a person-in-environment to an ecological systems approach, a major method of practice evolved from casework to case management. Moore (1990) contended that "case management" is a new name for traditional social work practice; however, case management has a stronger emphasis on professionals interacting with multiple systems that affect clients. In addition, case management emphasizes the use of a number of roles from counselor to advocate to educator to mediator. Social workers also "empower clients to become active participants and decision makers in all phases of their lives" (Sheafor, Horejsi, & Horejsi, 1991, p. 64) and help people find the power within themselves (Saleebey, 1992). This practice perspective is further reinforced by the strengths-based practice model (Rapp, 1992). Weick et al. (1989) emphasized that assessment and intervention based on the strengths of individuals is the cornerstone of empowerment: "Focusing on human strengths is one significant strategy for helping people reclaim a measure of personal power in their lives" (p. 354). The ecological systems perspective combined with a strengths-based case management approach that uses the principle of empowerment is a departure from the medical model and is a step toward the minority model.

However, the profession has not shown a consistent commitment to people with disabilities. The numbers of social work students and educators who have a disability are low, there are few disability-related articles in the social work literature, and social work conferences are nearly bereft of presentations on disability (Mackelprang, 1993). Likewise, people with disabilities have not regularly sought social work services (Servoss, 1983). One reason may be that social workers often practice in organizations such as hospitals and mental health centers in which professionals make the decisions, thus relegating clients to passive, receiving roles. Many social work jobs are also located in public-sector settings that are bureaucratic and cumbersome. Longmore (1987a) recounted the experiences of people with severe physical disabilities attempting to live independently: "severely disabled adults . . . must spend their lives confined to families' homes or imprisoned in institutions. . . . The very agencies supposedly designed to enable severely physically handicapped adults . . . to achieve independence and productivity in the community become yet another massive hurdle they must repeatedly battle but can never finally defeat" (p. 153). Longmore also offered illustrations of the catastrophic effects of public social policies in the lives of people with disabilities. When social workers are identified as the professionals who implement and enforce such policies and regulations, they are viewed with skepticism and distrust.

Empowerment has been a guiding tenet of both social work and independent living. However, independent living views empowerment from a different perspective than social work. Whereas social work envisions professionals involving clients or patients in prescribed care or treatment plans, independent living views social workers and other professionals as consultants only. Even when individuals have severe disabilities that limit learning and decision-making capabilities, social workers and other professionals teach skills and facilitate self-management but do not assume responsibility or control over people. In this manner people's capacities are maximized and abuses of power (for example, inappropriate institutionalization, involuntary sterilization, coerced treatments) are prevented.

Independent living proponents believe that the greatest constraints on people with disabilities are environmental and social. Social work, while acknowledging the multiple systems that affect people, often focuses on individual factors that contribute to client problems. Social work's tendency to intervene in personal problems without being asked is rejected by independent living proponents as intrusive.

Although social work has pioneered efforts to encourage the use of natural helpers in people's environments, departing from traditional reliance on professionals used in the medical model, independent living proponents assert that the informal support model still breeds dependence, shifting control from formal providers to informal providers (DeJong, Batavia, & McKnew, 1992). Independent living espouses a philosophy that advocates natural support systems under the direction of the consumer.
Social Work and Independent Living: Forging a Partnership

The lack of social work involvement in the independent living movement is disturbing because both have much to offer each other.

Benefits to Social Work

Social work can benefit greatly from a shift in focus from case management in which clients are labeled “cases” to a consumer-driven model of practice that acknowledges self-developed empowerment and not empowerment bestowed from others. The independent living movement has more than 20 years of experience developing and refining this approach. The following example illustrates the differences.

Sharon, age 32, received social work case management services after an automobile accident caused a spinal cord injury that resulted in quadriplegia. During Sharon’s hospitalization her social worker facilitated the procurement of Medicaid, ordered medical equipment such as a wheelchair, procured the services of a home health agency for home nursing visits, arranged for vocational rehabilitation services, and worked with Sharon’s family to prepare for her discharge from the hospital. Similar case management services were provided for six months after discharge; the social worker generally informed Sharon of the services she would be providing, and Sharon also made requests for services.

Six months after discharge from the hospital, Sharon became involved with a local independent living center for peer counseling and independent living training. When Sharon began to have trouble with Medicaid, she asked the independent living counselor to intervene on her behalf. Similarly, she asked the counselor to procure a commode chair. Rather than meet her requests as the social worker had done, the independent living counselor taught Sharon to self-advocate with Medicaid and guided her through the process of ordering medical equipment so Sharon could do so in the future. In addition, the counselor informed Sharon how she could gain access to a program in which she could hire and direct her attendants rather than having nurses and aides assigned to her. Sharon developed the knowledge and skills to direct her own personal care, including hiring, firing, and money management, essentially reclaiming control over her life.

The social worker viewed her interventions on Sharon’s behalf as client centered and empowering. She took control in the immediate weeks and months after Sharon’s accident because “to ask Sharon to do so would be overwhelming because Sharon needed time to adjust” to her injury. As time progressed, the social worker maintained her involvement level because working with so many agencies was “complicated.” Her actions empowered Sharon because she was able to access numerous services. The social worker always informed Sharon of her plans to assist Sharon, and Sharon often requested the services the social worker provided. The social worker cited her close relationship with Sharon and Sharon’s appreciation of her efforts as evidence of the effectiveness of their relationship.

Although the social worker’s activities helped Sharon, the social worker unintentionally encouraged dependence and impeded Sharon’s self-determination. The independent living counselor, on the other hand, saw her role as facilitating Sharon’s self-determination, and she did not consider directly intervening in activities Sharon was capable of. Through mutual exploration with the counselor, Sharon was able to greatly enhance her independence in several areas.

Benefits to the Independent Living Approach

If the person-in-environment approach can be criticized for being too intrapsychic, the independent living approach can be criticized as viewing problems too much from an external perspective. Independent living may be too quick to assume that consumers already have knowledge and abilities rather than recognizing that they may need assistance to develop their strengths. The following example illustrates the differences.

Jim, age 28, had a traumatic brain injury. He sought assistance with budgeting and financial difficulties at an independent living center. The independent living counselor, who was also an
MSW student in practicum, helped Jim develop a budget and strategies to deal with creditors. During the sessions with Jim, it became apparent that his head injury was also a contributing factor to significant marital and family difficulties. However, because these problems were not problems identified by Jim, the counselor felt constrained from intervening in this area.

Jim seemed relatively unconcerned by his marital situation (almost certainly because of lack of insight as a result of his head injury). However, his wife and adolescent daughter were in significant distress. Competent counseling was available at the independent living center but was inaccessible unless Jim identified problems and requested help. Although his family could seek counseling at a mental health center, this center did not employ people who understood the implications of brain injury. Therefore, no marriage reconciliation services were provided. Jim and his wife later separated and divorced, and Jim’s wife maintained primary responsibility for their child. By the time Jim became responsive to the need for help, it was too late to save his marriage.

In Jim’s case, the independent living approach resulted in a lack of intervention, which ultimately had negative effects on Jim and his family, in part because independent living’s narrow view of the consumer does not include the family. This case also illustrates the conflict between absolute self-determination and the need to sometimes impose professional intervention. Although some would argue against any change in Jim’s intervention, a social work approach would have allowed for broader intervention and ultimately may have been more empowering to Jim and his family.

Conclusion

Social work and the disability movement have much to offer each other. However, before both can forge a partnership, the social work profession must work to increase the low numbers of social work students, practitioners, and educators with disabilities (Mackelprang, 1993); re-examine its attitudes and beliefs about people with disabilities (Salsgiver, 1993); provide disability-competent education; and become more involved in disability advocacy work in agencies with activist philosophies. Social work can contribute decades of experience with the ecology of society and multiple systems. The disability movement can help social work enhance approaches to clients, better empower oppressed and devalued groups, and understand the needs of people with disabilities. It is a partnership that is long overdue.

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