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Practice Guidelines

If you [professionals] don't believe that disabled people can achieve, get out of the way. [The professionals] need to learn as much as they can to help ensure that disabled people are given the tools we need in order to move ahead in our lives. Professionals who work with kids need to give their parents positive images of their children's abilities and possibilities. They should not limit people's thinking; they should help expand people's horizons. They need to understand the implications of discrimination and bias in order to allow people to remedy those problems. They need to be part of the solution, not part of the problem.

—Judy Heumann, assistant secretary, Office of Special Education and Rehabilitation Services

STUDENT LEARNING OBJECTIVE

To develop intervention skills with persons with disabilities based upon strengths, self-management, independent living, and empowerment approaches.

Six principles guide our approach to working with persons with disabilities. First, we assume that people are capable or *potentially* capable (Cowger, 1994; DeJong, 1979; Gutierrez, 1990; Saleebey, 1992; Solomon, 1976; Tower, 1994; Zola, 1983). When people lack insight, knowledge, and skills, professionals are responsible for helping them become insightful, knowledgeable, and skillful. For example, professionals may need to help people with intellectual disabilities develop knowledge and skills to manage financial matters to the greatest extent of their ability. It is the human service professional's responsibility to facilitate the mobilization of resources to help people achieve their greatest potential. When people lack the ability for the whole, we assume they are capable of parts of the whole. For example, persons with intellectual disabilities may not be able to handle all their financial matters but should manage the elements they are capable of handling. Similarly, people with quadriplegia may be physically unable to dress themselves;

however, they are capable of directing who provides attendant care and how and when it is provided.

We should constantly evaluate people's capacities and potential. As people develop, their capabilities grow. New capabilities should continually be assessed, nurtured, and maximized. When determining capacities, we adopt the minority view and work to reject the imposition of the dominant society's views of the capabilities of disabled persons individually and as a group (Zola, 1983). As an illustration of the minority view, one of the authors spent several years of his childhood and adolescence in an institution because the dominant culture determined he needed to be made as physically "normal" as possible. The majority decided that institutionalization, multiple surgeries, and removal from his family and community were necessary for him to function adequately and fit into society. Dominant cultural and professional values led professionals to make decisions that were inhumane and dehumanizing to a child. Like others with disabilities, the author needed adequate resources, advocates who valued persons with disabilities, and role models with disabilities. Instead, he was institutionalized, isolated, and ostracized by society. (His story is told in the case examples at the end of the chapter.)

Second, we reject traditional methods of practice that assume that the problem with disability lies with the person and that individuals with disabilities must change or be "fixed" before they can function adequately in society (Blotzer & Ruth, 1995; DeJong, 1979; Emener, 1991; Hahn, 1991; Zola, 1983). We reject the pathological interpretation of disability, along with its belief that disability requires grief and mourning, "equating disability to death" (Salsgiver, 1996, p. 18).

Third, we believe that any model of practice for working with disabled persons must assume that disability is a social construct and that a primary emphasis on intervention must be political in nature (DeJong, 1979; Fine & Asch, 1993; Tower, 1994; Zola, 1983). As a whole, persons with disabilities constitute a unique group that brings contributions and experiences that enhance society. As a minority group, they have suffered oppression just as people of color, women, gays and lesbians, and older persons have suffered oppression (Mackelprang & Salsgiver, 1996). The solutions to problems faced by persons with disabilities rest primarily in access to society's resources and rewards. Environmental, attitudinal, and policy barriers to participation in society must be eliminated.

Fourth, we believe there is a Disability history and culture. Even though different people may have different disabilities, they have more in common than they have differences. Because of the shared experience of oppression, containment, and isolation, it is imperative that anyone working with persons with disabilities be knowledgeable of the history of oppression that this group has experienced. In addition, they need to be aware of political

figures, advocates, and conveyors of Disability culture and how they have contributed to the fight for respect and disability rights. Furthermore, practitioners need to be highly knowledgeable about political advocacy. They must be willing to help consumers become politically involved (Tower, 1994).

Fifth, although disabled individuals and disabled people as a group have experienced oppression, we strongly believe that there is joy to be found in disability and richness in the experience of living with disability. Models of practice for working with persons with disabilities must view “disability as different and not necessarily dysfunctional.” They should “view a child with a disability as one more panel of color, which makes up the glorious tapestry of human existence” (Salsgiver, 1996, p. 23). Indeed, we believe that disability is beautiful and that most people with disabilities are actually happy with themselves and their lives (Hahn, 1993; Mackelprang & Altschuler, 2004).

Sixth, we believe that persons with disabilities have, *without question*, the right to control their lives (DeJong, 1979). This means that the consumer controls the professional’s involvement. This means that the professional brings expertise to the consumer, which he or she can reject or accept, or reject in part or accept in part (DeJong, 1979; Hahn, 1991; Zola, 1983). Consumers have the right to walk or roll away from services and interventions they believe are not in their best interests. The natural place for persons with disabilities, even if professionals disagree with their choices, is in control of their own lives, living independently of custodial environments, with the same rights and opportunities as nondisabled persons.

INTEGRATING A POSITIVE DISABILITY IDENTITY

In addition to the preceding principles of practice, we believe human service practitioners must also be aware of the need for persons with disabilities to develop healthy self-identities. This changes the focus of human service practice from repairing individuals to helping people develop a healthy self-identity in a society that accepts and values them, disability and all. This process has many similarities to the process of positive identity development for sexual orientation/sexual identity minorities (Chan, 1989; Coleman, 1982; Troiden, 1993). Like sexual minorities, persons with disabilities may experience a coming out process as they integrate disability into their self-images. In our experience, positive disability identity develops differently in different people; there are no stages people must experience to reach an ultimate positive disability identity. However, human service practitioners may identify processes that are commonly experienced. The processes listed here are based on the work of Onken (Onken & Mackelprang, 1997), who applied

them to persons with disabilities and to sexual orientation/sexual identity minorities. They can aid professionals in identifying consumers' experiences.

Preawareness conformity is characterized by an unquestioning acceptance of societal stereotypes and oppression. The person is unaware of alternate positive views of disability and attributes problems to personal deficits. *Contact* occurs when an individual is exposed to challenges to ableist views of disability. The individual may be oblivious to the personal implications of ableist oppression but may begin to feel different from others because of his or her disability. In the *denial or avoidance* stage, the person rejects the implications of ableism and oppression. Some may acknowledge the implications for others but deny being personally affected, some attempt to pass as nondisabled, and some distance themselves from others with disabilities and reject membership in this marginalized population. *Comparison* is a process in which the person begins to develop an awareness of the reasons for which he or she feels different. The individual develops a heightened sense of not fully belonging in ableist society and begins to recognize the disadvantages of having a disability in ableist society and the sense of disempowerment that it brings. As a result of this increased awareness, the person may begin to feel *confusion and dissonance*. There can be a growing sense of personal isolation and lack of group identity. The person may acknowledge that he or she is a member of the disability community but may be reluctant or refuse to claim membership. There may be a feeling of "I'm not like them" or "I don't want to be around them." Feelings of isolation can lead to *tolerance*, as the person begins to acknowledge membership in the disability community. The individual may seek out others with disabilities to increase socialization and avoid isolation and may experience a heightened sense of alienation in an ableist society. *Connection* occurs as an individual experiences feelings of kinship and begins to develop an identity with the community of persons with disabilities. Disability is seen in a positive light. Respect for others with disabilities grows, and a positive disability identity is enhanced. *Immersion and resistance* occur for some people, who may react in the extreme by rejecting and retreating from ableist society and maintaining nearly exclusive contact with the disability community. Persons involved in the Deaf separatist movement (as well as the lesbian separatist movement) provide examples of this process. Some find permanent happiness in this state. *Acceptance and pride* are related to immersion and resistance, but reactions are less extreme. An individual may begin to actively challenge ableist practices and beliefs, and a sense of disability pride develops. An example of this is the adoption and proud use of labels (e.g., "cripple," "gimp," "crazy") that have commonly been used to demean. *Introspection and synthesis* occur when an individual balances personal and community disability identity with other identities, memberships, and relationships. There is a renewed appreciation for diversity, a sense of the value of universally accessible multicultural societies. An individual feels comfortable with

disability as a form of diversity, continues to acknowledge the societal implications of living with a disability, and may feel less anger and stridence. “The person seeks to be competent in disabled-nondisabled (and/or sexual minority-sexual majority) interactions, including ongoing self-assessment, attention to the dynamics of difference, and expansion of knowledge, resources, and adaptations in order to better connect with people regardless of difference. The person is comfortable in challenging and in developing allies in challenging ableist (and/or heterosexist) practices and beliefs and corresponding oppression” (Onken & Mackelprang, 1997, pp. 25–26).

HUMAN SERVICE PRACTICE FUNCTIONS

The six pillars outlined above, combined with a disability-affirming approach, guide our practice with disabled persons and communities. They provide a foundation of empowerment with a strengths orientation that takes into account the biosocial, psychosocial, and social structural systems in which persons live. Given these pillars, effective human service practitioners must function at multiple societal system levels. We believe that effective clinical or direct practice must involve intervening at the institutional and societal levels. Similarly, administrators and community practitioners must make decisions in the interests and with the input of individuals with disabilities and the disability community.

In this section, we outline the four major functions of human service practitioners working with persons with disabilities: counselor, teacher, broker, and political/policy activist. Within each of these practice domains, practitioners may engage in a variety of roles such as mediation, advocacy, facilitation, enabling, education, referral, and therapy.

The functions of counselor and teacher are manifested primarily at the micro- and meso-systems levels with interventions directed toward biosocial and psychosocial well-being. The function of broker spans micro, meso, and macro levels, and interventions occur in all three social-ecological domains. The function of political activist/policy activist plays out primarily in the meso and macro arenas, with interventions occurring in the social structural domain. Functions may overlap with each other; however, to be comprehensive, we discuss them as discrete entities. All these functions are based on a consumer-driven independent living approach. All are based on the belief that actions at one level influence other levels. In other words, personal actions and interventions are political and affect the community, and political interventions are done with individuals in mind.

The human service practitioner as counselor

The function of counselor is multifaceted and goes well beyond the traditional role of clinical psychotherapist. We see Solomon’s role of sensitizer

(1976), in which practitioners sensitize consumers to the oppression that persons with disabilities experience and how oppression can affect sense of self, self-esteem, and the ability to gain personal and political power, as a critical component of the counseling function for human service practitioners working with persons with disabilities. Sometimes awareness of oppression lies buried, which prevents people from developing the self-concept necessary for success defined in their terms. Sometimes the denial that allows persons with disabilities to survive and mature (Wright, 1983) also can become a hindrance when attitudinal, social, and environmental factors begin to destroy the "reality" found in the denial. In the role of counselor, the human service practitioner helps disabled persons develop an understanding of that process and understand themselves and their disability identity in a positive light (Blotzer & Ruth, 1995; Sullivan & Scanlan, 1990). Therefore, an understanding of the impact of oppression on persons with disabilities is crucial to the counseling role of human service practitioners.

Wright (1983) makes the following statement concerning people with physical disabilities, which can be applied to all persons with disabilities: "Physical limitations per se may produce suffering and frustrations, but the limitations imposed by the evaluative attitudes toward physique cut far deeper and spread far wider; they affect the person's feelings about himself as a whole. One of man's basic strivings is for acceptance by the group for being important in the lives of others, and for having others count positively in his life. As long as physical disability is linked with shame and inferiority, realistic acceptance of one's position and one's self is precluded" (p. 14).

The function of counselor requires the exploration of this domain. Sometimes counselors and consumers/participants must explore the personal effects of this negativity and stereotyping. It may be especially difficult when people explore the effects of these perceptions on how their family members, loved ones, and others perceive and treat them. For example, persons with physical disabilities whose parents subjected them to futile surgeries and other painful procedures as advised by health care providers may harbor a multitude of feelings. They may acknowledge their parents' love but harbor resentment toward them for the unnecessary pain they suffered. They may struggle to form a positive disability identity. They may also need help reestablishing and redefining relationships with family and friends. In these instances, practitioners may utilize multiple roles, such as that of the therapist to help individuals adjust to events and traumas associated with their disability, mediator of communication between disabled individuals and others, and facilitator of referrals to resources.

When disabilities are acquired later in life, counselors can help consumers in a number of ways. They can provide therapy to help individuals and loved ones cope with the adjustment and personal loss many experience. Just as importantly, they can help them understand ableist societal attitudes and help them develop new perspectives on disabilities. Peer counselors can

often fill this valuable role by exposing individuals to competent, adjusted persons with disabilities who can guide them in dealing with devaluation and stereotyping.

There are a variety of other counseling roles that human service practitioners can fill. Group counselors can facilitate groups of persons with disabilities in coming together to share personal experiences and life stories. Interaction and sharing help people develop Disability identity and culture. Resource counseling is a role in which practitioners counsel consumers and teach them about community resources and how to utilize them. Family counselors can help consumers and their loved ones understand and cope with the vicissitudes of life. Educational counseling is a role in which practitioners teach participants about a variety of concerns, such as biosocial and sexual functioning.

The primary function of disability counseling is to help individuals cope with life and function within their social environments and society. Counselors can facilitate the coming out process discussed earlier in the chapter. It is critical that counseling be participant driven and that it focus on people's strengths and potential. Counseling is provided in the context of helping people understand the ableist society in which they live and how to use their strengths to chart a positive life course and to overcome oppression and reject devaluation.

The human service practitioner as teacher/consultant

A second major function in human service practice is that of teacher/consultant. The human service practitioner teaches the participant only about those areas about which the consumer seeks to learn. In other words, the teacher is a consultant rather than an educational director. Teaching by the human service practitioner covers three basic areas: (1) personal techniques for identifying capabilities and for dealing with the results of oppression, (2) self-management and self-advocacy, and (3) political advocacy. Consulting in the first two areas is similar to the counseling function. However, we place them separately because of the strong social and community emphasis involved in teaching about these areas.

Learning about strengths and capabilities and about the pernicious effects of oppression helps people eschew dependency, which creates non-assertiveness and passivity (Sussman, 1977). Passive, conforming behavior results in social isolation (Orr, Thein, & Aronson, 1995) and the inability to function successfully in employment and in the political process. The first step in helping overcome dependency and passivity is to teach the person about the societal forces imposing negative stereotypes, about incorporating disability into the definition of self, and about developing assertiveness

(Joiner, Lovett, & Goodwin, 1989). Smith's (1975) classic model of assertiveness training is still relevant for practice today. It involves teaching about the dynamics of guilt and shame and how to develop assertive verbal and behavioral skills. Assertiveness also involves self-disclosure and individual persistence in getting needs met.

The next step in teaching and consulting involves helping people modify their expectations and acknowledge and demand their rights. For example, individuals can be helped to develop personal assertiveness in a job interview by recognizing their strengths and asserting their needs. In addition, employees can convey the expectation that employers make workplaces accessible. Expectations of access expand to the community as individuals begin to expect accessible communities as a basic human right and as a societal responsibility.

The second area of teaching lies with self-management and self-advocacy. Rather than acting as a case manager, we see the role of the human service practitioner as teaching personal management skills to persons with disabilities so that they can manage their lives themselves. Based upon the IL model of practice, areas of teaching in self-management and advocacy include peer education and support, transportation, attendant care, accessible housing, and personal advocacy.

As discussed previously, the sharing of the disabled experience is crucial in the lives of persons with disabilities. There are some experiences that can only be understood within the disability community. Consumers can derive great benefit from contact with peer counselors, role models, and others with disabilities. Human service practitioners must first have knowledge of neighborhood and community resources offering peer support and of disability advocacy groups. They may need to show disabled individuals how to link with services in person, by phone, and/or electronically. Practitioners may need to make referrals and pave the way so that persons with disabilities can begin to involve themselves in the disability community.

Self-advocacy may also entail teaching a person with a disability to use public transportation. If public transportation is not available, the human service practitioner may have to help arrange alternative transportation, but the consumer must be fully involved in this process (Cole, 1983). When accessible transportation is problematic, the human service professional may need to teach the consumer how to begin the political process and facilitate pressuring local government and government transit agencies to develop accessible transportation (Bowe, 1983).

Self-advocacy is also critical in other areas. Some consumers with disabilities need attendant care. They may need to be taught how to access attendants through independent living centers, local government agencies, or private means (DeJong & Wenker, 1983). In addition, consumers may request training in how to manage personal attendants. Attendant management training includes interviewing, hiring, training, and firing attendants.

Human service practitioners must be knowledgeable about management issues and techniques in order to teach them to consumers. Consumers may need education to avoid problems such as physical abuse and the development of romantic relationships with attendants. Strategies for boundary maintenance between employee and employer can help prevent these problems.

Another important area in which many persons with disabilities request training is the acquisition of accessible housing. This means that persons with disabilities may need to modify existing housing or seek out accessible housing. The human service professional may need to be aware of or have access to existing accessible housing options. In addition, the human service practitioner may be able to help the consumer access private contractors who provide modification services (Wiggins, 1983). Just as with the issue of transportation, it may be necessary for the human service professional to help the consumer advocate the addition of accessible housing and the enforcement of existing codes and laws requiring both public housing entities and private buildings to be wheelchair accessible.

Another component of self-management is personal advocacy, which involves teaching consumers techniques for asserting their rights and acquiring the things they need or desire. Becoming a self-advocate begins with an understanding of the impact of oppression and lack of opportunity. Then consumers need to develop assertiveness skills, as discussed earlier, and to work within the agency or organization providing the services to achieve their goals. At times, self-advocacy involves going outside existing social agencies and institutions. For example, consumers may seek legal solutions or redress to force institutions to meet their needs.

In our model, the final educational role for the human service professional centers on political advocacy. The passage and implementation of disability policies discussed in chapter 5 were accomplished in large measure due to the political efforts and social activism of disabled persons and advocacy groups. Shapiro (1993) chronicles the movements controlled and directed by persons with a variety of disabilities, which resulted in a range of historic U.S. legislation, including the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. Subsequent efforts by disabled people and disability rights groups have produced laws and policies to enhance the lives of disabled people worldwide.

Social activism and education begins with the practitioner being knowledgeable of these various political undertakings and communicating the importance of political activity to the consumer (Tower, 1994). The next step involves helping the consumer access the local groups involved with political advocacy around disabilities. National and international disability advocacy groups have proliferated in recent decades and can be easily found on the Internet. The independent living movement has spread to multiple

continents and continues to gain momentum. Practitioners can teach consumers about the political decision-making process and how to connect with local, regional, national, and international political and policy representatives. They can provide disabled persons with lists of the politicians who represent them and can help mobilize consumers to access them. Strategies ranging from cooperation to co-optation to confrontation can also be taught. Consumers can be taught skills such as how to testify before legislative bodies, interview with the media, and participate in political demonstrations. Tower (1994) states: "Consumers need good role models if they are to become more autonomous. In direct practice social workers can demonstrate good advocacy skills, teach strategies for effective communication, and coach clients through the maze of policies and procedures. They can commiserate about the inequities and absurdities that are ubiquitous to the human services. Meanwhile, they can encourage their clients to take purposeful action to improve their condition through self-advocacy and organization with peers" (p. 195).

In teaching self-advocacy, human service professionals should not be directive. However, by developing political knowledge and skills and passing them along to consumers, human service practitioners can facilitate consumer empowerment.

The human service practitioner as broker

Human service practitioners may be called upon to act as social brokers. Brokers identify and help consumers gain access to resources. It is important for human service practitioners to involve consumers in the brokering process as much as possible and to help consumers develop brokering and self-advocacy skills. Effective brokering requires human service practitioners to know which agencies within the community provide the services that disabled individuals need. Next, brokering may require practitioners to know how to utilize agency personnel and policies effectively. For example, there may be a certain administrator or supervisor in an agency or a particularly conscientious worker with whom the human service practitioner can broker to access services. Brokering requires practitioners to pass on their knowledge of how to access resources to consumers and to help them develop personal brokering skills. They can teach consumers how to make phone calls, write letters, and participate in meetings with bureaucrats. Consumers may also need to learn how to connect the services of various agencies and how to organize others with disabilities. Practitioners can strategize, advise, and support consumers as they begin to broker for themselves (Tower, 1994). Finally, practitioners can organize groups of disabled people and their allies to influence policy and practice.

Brokering and facilitating self-advocacy requires work on the micro-, meso-, and macro-systems levels as practitioners assess situations and intervene with individuals as they come in contact with larger systems and communities. Interventions at these levels require helpers to assess community strengths and limitations. Direct service practitioners must consider the impact that meso and macro systems have on people and, reciprocally, how people and groups can affect these systems. In conjunction with participants, they can plan and implement strategies to enhance the responsiveness of larger systems.

Meso- and macro-level practitioners also act as social brokers in working to help communities become more responsive to people's needs. They may act as consultants to help individuals and groups of people with disabilities learn how to affect communities. Because professionals often hold status and power, they may fill the role of advocates in working to create positive community environments. Community developers and social planners can broker disability-friendly environments as well as call policy developers within agencies and organizations. The role of mediator can also be valuable in connecting people and organizations as well as in interceding between organizations.

Human service professionals who work at all systems levels on behalf of persons with disabilities should remember that their ultimate goal is to help people self-advocate by realizing their own personal potential and by using their skills. The various roles used should be directed at helping persons take control. We can use our expertise to help people examine their problems and needs. We can advocate adequate resources and accessible communities. Ultimately, however, it is persons with disabilities who offer the strongest voice and direct the struggle for self-determination.

The human service professional as political/policy activist

Our model stresses that human service professionals work at the meso and macro levels for political change around issues relating to persons with disabilities. Political/policy activism requires practitioners to advocate for individuals and social causes. Traditionally, however, there have been conflicts of interest between professions and communities of disability. For example, large institutions that rely on the medical model of treatment have been used for centuries to warehouse persons with intellectual and mental health disabilities. As these facilities close down, human service jobs, including nursing, social work, and medical jobs, are lost, and human service professionals are forced to find different roles. Practitioners may need to acknowledge that political advocacy on behalf of disabled persons and groups can have negative effects on their traditional professional roles. We believe, however, that there is a place for the human service professions if we are proactive in

working with persons with disabilities to carve out niches that focus on their strengths and their empowerment. Human service professions can join forces with consumer-directed organizations and movements. Collaboration between professional organizations and these groups increases trust and understanding and fosters consumer-professional interdependence (Condeluci, 1996). The convergence of diverse groups of persons with and without disabilities has led to the passage of civil rights laws and the implementation of disability policies worldwide. Public support for entities such as centers for independent living has grown as disabled people and the disability community have advocated for themselves in conjunction with professionals and other allies. Policy makers have listened and acted in response to the increased power shown by activists and other advocates. As the human service professions begin to welcome increasing numbers of persons with disabilities as colleagues and peers, we will be increasingly equipped to act in the roles of advocates, brokers, community planners, and policy developers.

This means that human service professionals must be taught political skills by human service educators (Tower, 1994). It means that human service professionals must become involved with local, state, and national elections by volunteering time and money. And it means that human service professionals must access politicians and policy makers to support laws, policies, and programs that empower and promote the independence of persons with disabilities.

CASE EXAMPLES

We include several case examples here to illustrate and identify major points made throughout this chapter and to help readers apply the principles used in the text.

The Author

An understanding of the impact of oppression on persons with disabilities is crucial to the counseling role of human service practitioners. The life experience of one of the authors, Richard Salsgiver, reflects the impact of devaluation and oppression, the importance of role models and the disability community, and the resilience of human beings. The author was born with cerebral palsy, was institutionalized between the ages of six and twelve, and received a master's degree in social work and a doctorate in history as an adult. He moved to California in 1984 at the age of thirty-eight. As you read his story, identify the impact that the dominant view of disability has had on his life. Take into account the decisions made concerning him during his childhood, his self-perceptions, and the process of coming out with a disability to himself and others. In addition, identify the role a counselor played in this process.

I came to California in 1984 after being a successful mental health worker in a private psychiatric/school facility in western Pennsylvania. My first job in California was as a social worker working with people with intellectual disabilities at the Golden Gate Regional Center in San Francisco. The first day on the job I met a person, herself a person with a disability, who would become a lifelong friend. When I referred to myself over lunch as “handicapped,” she jumped down my throat. She informed me that the correct term was “person with a disability.” I replied that it didn’t really matter what I called myself. She replied that it did. She proceeded to tell me about the independent living movement, a story (which I didn’t realize at the time) that would change my whole life.

In Pennsylvania, my friends and professional colleagues rarely acknowledged my disability. I never perceived myself as a person with a disability. I remember catching a glimpse in a store window of myself walking with my crutches, and being taken aback and feeling that this was not really me. I negated my need for accommodation. I bought a three-story house that sat on a bank with stairs leading up to the entrance. It had no garage. Even though it was hell getting to it in the winter, I never let my disability enter into my decision to purchase the house.

At my work, issues of accessibility were not even an afterthought. I remember going to a social work conference where I slipped and fell on the ice. The injury to my hip was so severe that I could get into my car only with great difficulty. I pulled myself in and drove home; however, I could hardly get into the house. The next day, when I took two students to the local community college to meet with the admissions counselor, I refused to acknowledge the pain in my hip or the fact that I could hardly walk with my crutches. I had to prove that I was not like the rest of them. This incident is representative of my attitude at the time, supported by my friends and colleagues, that I was not really handicapped.

In California, things began to change. I quickly became immersed in the independent living movement. I took a management position at the Center for Independent Living in Belmont, California. There I became involved not only in the practice of independent living but in politics and political advocacy on all levels. In 1986, I moved into the executive directorship of the California Association of the Physically Handicapped (now the Center for Independent Living) in Fresno, California. Here I was truly engulfed in disability. The majority of my staff were persons with disabilities. The members of my board of directors were persons with disabilities. The professionals at the state and national levels with whom I worked were mostly persons with disabilities. I began to feel resentment and anger, and I didn’t know why. I began to hate to come to work and to hate dealing with my staff and board. My hatred and anger turned into depression, and I sought help. One of my staff members told me about a local social worker in private practice she had met at a party, and who seemed really good. I called him. Fortunately, the therapist understood disability and the oppression around disability. He opened up points of understanding that had been hidden in me for years. We explored my years of institutionalization and society’s stereotypes of persons with disabilities. We explored the impact of the stereotypes on my family and how that influenced their treatment of me. This

knowledge helped me understand my anger and resentment toward my colleagues and other persons with disabilities. That knowledge allowed me to embrace myself as a person with a disability as a positive self-loved being. It allowed me to embrace other people with disabilities as truly beautiful and whole.

In the years since I started integrating my disability into my concept of self, I have witnessed others as they have struggled with the shame and internalized ableism and sought to embrace themselves, disability and all. I have seen persons with disabilities acting as mentors, helping others integrate disability into their definition of who they are. One tremendous source of personal strength is my tie to an international disability community that is just beginning the long journey of changing how society perceives us. This community has fostered a collective disability pride and identity.

Robert and Lisa

The following is the case example of Robert and Lisa (pseudonyms), two young nursing facility residents with quadriplegia from neuromuscular disabilities who were able to leave the nursing facility in which they lived and begin living in the community. Their case, which was mentioned briefly in chapter 13, provides readers an opportunity to assess human service practices. Contrast the impacts of the social model and the medical model approaches used to identify their problems and apply intervention strategies. Had a traditional model of intervention been employed, what strategies would likely have been used to help Robert and Lisa? What was the impact of self-determination and community resources in their lives? What systems and system levels were targets for professional intervention? Identify professional functions and roles utilized. In what areas of personal advocacy and self-management did Robert and Lisa participate? Identify community resources employed to enhance their lives. Describe the relationship and power balances between professionals and consumers.

Robert and Lisa were in their mid-twenties. Both resided in a large nursing facility with a unit devoted to young residents (under sixty years of age). Robert had come to the nursing facility to leave his small community and live in an urban area. Lisa left her parents' home because she wanted to "break away" and live "on my own." When they met in the nursing facility, they fell in love. They wanted to room together, but the nursing facility staff, with the strong concurrence of Robert and Lisa's families, refused.

A social work consultant was brought in by the nursing facility with the consent of Robert and Lisa. Nursing facility staff members were concerned that Robert and Lisa were not ready for a sexual relationship, emphasizing their physical limitations. They also identified Robert as borderline mentally retarded and depressed. Lisa was diagnosed with depression and as lacking social skills. Robert and Lisa were upset that the nursing facility did not allow them freedom and self-determination.

The social worker was initially sought to provide counseling for the couple. Individual and couples counseling were provided; however, it was clear that meso-level interventions were needed. Robert and Lisa both expressed a strong desire to live in the community and become more autonomous.

At the meso level, the social worker began acting as a mediator between the couple and the nursing facility so that Robert and Lisa could spend more time together in their courtship. The social worker helped the couple articulate their needs. They were able to reach an agreement about dating outside the facility and were allowed to alter their schedules and activities inside the facility. The facility had to expend more resources to meet their demands. Robert's borderline diagnosis had been used to withhold decision-making authority from him. He now wanted to challenge this pattern. The nursing facility's corporate office used this diagnosis to stop the couple from rooming together because of concerns about liability if they became sexually active. The social worker acted as a broker by helping Robert contact a legal center that provided services to persons with disabilities. They helped Robert assert his right to self-determination by having him judged competent to handle his own affairs. The nursing facility was then forced to deal with Robert exclusively rather than relying on the wishes of Robert's parents, which sometimes conflicted with Robert's desires. This opened the door for Robert and Lisa to room together.

Robert's and Lisa's case forced the nursing facility to reassess its practices relative to unmarried persons rooming together. The social worker was instrumental as a policy developer in helping the facility develop policies that would allow for greater self-determination of its residents.

The role of community developer was critical for the social worker. Robert, Lisa, and others in similar situations were catalysts for creating non-institutional community living situations for persons with disabilities. With the involvement of several consumers, professionals, and agencies, community living resources were developed to allow people with physical disabilities to live outside institutions. Robert, Lisa, and others were anxious to let people know they were in nursing facilities not by choice or need, but because there were no resources for them to live outside nursing facilities. The social worker acted as an educator to help them make their stories known and to self-advocate. At the same time, Mona, a woman with a spinal cord injury, went public with a news story chronicling her plight of being forced to live in a nursing facility. She demonstrated that she could live in an apartment with attendant care, at much less cost to the state than living in an institution. Robert and Lisa attended a city council meeting to ask them to set aside public housing for people with needs similar to theirs. The social worker who worked with Robert and Lisa, along with other human service workers, acted as a consultant to help them determine effective strategies, but Robert and Lisa were responsible. At the request of consumers, human service workers acted as advocates to help increase access to housing, transportation, and community independent living services.

Eventually, Robert and Lisa located housing outside the nursing facility. The community housing authority provided subsidized accessible housing, and the state social services agency provided funding for personal care attendants. Lisa (and Mona) moved into individual apartments. Robert moved to a residence with three roommates with disabilities. He continued to consult a human service

professional for financial planning help but controlled his personal affairs. By the time they moved out of the nursing facility, Robert and Lisa's relationship had developed platonically, and they remained friends.

Theron Sloan

The case of Theron Sloan (pseudonym) is an additional example of the use of multiple professional roles in direct service provision. Identify the roles of the direct practitioner. What was the power balance between Theron and the practitioner? What are the strengths and weaknesses of the approach used by the clinician on a systems level? What are the advantages and disadvantages of this approach for nondisabled family members of persons with disabilities? What were the circumstances that allowed Theron to use other professionals as resources? How were Theron's relationships with other professionals influenced?

Theron Sloan was a twenty-seven-year-old male with a disability from a closed head injury sustained in a motorcycle accident that occurred six months prior to his seeking help from a social worker. As a result of his head injury, Theron had left-sided weakness and was on medication for seizures. He also had short-term memory problems and would lose control emotionally under stress. He had worked, prior to his disability, as an accountant. His primary reason for seeking counseling was for help with depression. The social worker began individual counseling and worked with Theron on issues of self-esteem and reclaiming control over his life. He also began to educate Theron on strategies to help him compensate for his memory difficulties, such as keeping a log of activities and writing down his plans and activities at the beginning of each day.

Early in the relationship, the social worker realized Theron was having marital difficulties and suggested that Theron consider marriage counseling. When Theron declined, the social worker respected his wishes and did not push for marriage counseling, even though he knew marital problems were an ongoing stress. Although the social worker was not employed in an independent living center, he used an IL approach, reasoning that Theron was capable of deciding on interventions that were in his best interests.

During counseling, Theron revealed that he had been having difficulty with his physician, whom he felt was unresponsive to his needs. He was frustrated because he wanted to work again but was unable to return to his previous employer. In addition, he felt socially isolated from others. The social worker could have acted as a case manager by arranging for various services. Using an independent living counselor approach, however, he began planning with Theron to address his problems. Theron wrote out a list of his frustrations with his physician; he and the social worker then role-played a conversation with his physician about the concerns on the list. The social worker identified a vocational rehabilitation counselor with whom Theron could work. Theron called the counselor from the social worker's office, using the social worker as support. The social worker also gave Theron the names of key people in the head

injury community who could act as resources. In these activities, the social worker used the roles of consultant and broker.

Theron maintained his relationship with the social worker for a period of several months. At one point, Theron disclosed that he and his wife were having sexual problems and requested help. The social worker, acting as a marital therapist, provided help for the couple's sexual problems. The social worker also referred Theron to a physician to evaluate the effects of his physical problems and medications on his sexual functioning.

A. Bruce Benet

In reviewing the case of A. Bruce Benet (pseudonym), identify elements of self-advocacy and personal empowerment. Discuss the impact of defining Bruce's personal problems in their social context. What was the value of a peer counselor in this scenario?

A. Bruce Benet had developed a malignant tumor at the base of his spine, which, when removed, left him paralyzed from the waist down. He was released from a local rehabilitation hospital and referred to a peer counselor at the local independent living center. Bruce exhibited long periods of depression with occasional outbursts of anger. At his first session, he was an hour late for his appointment. The lift on the local transit bus broke halfway into the process of loading Bruce and his wheelchair. The driver told him that all the lifts on the buses were in poor repair but the county refused to allocate money to fix them. Upon arriving at the independent living center, he was furious. He told the peer counselor (after he waited for another hour because of the counselor's next appointment) what had happened. The peer counselor suggested that he attend the local transit advisory meeting, where citizens can give input on transit issues. The peer counselor informed Bruce of the place and time of the next meeting. When Bruce expressed his intent to attend, the peer counselor told Bruce to let him know at the next session what had happened.

At the next session, Bruce was like a different person. He was neither angry nor depressed, but intense. Attending the meeting was a singular event for Bruce. He told the counselor that at the meeting there were two other wheelchair users angry about the same thing—lifts on public buses that didn't work. The county representative blew off their statements, saying that there was simply no money to fix the buses. After the meeting, Bruce got together with the other two concerned citizens at the local watering hole. They decided to form a political action group to force the county to put more resources into making public transit accessible.

The peer counselor, a wheelchair user himself, listened intently. He offered to come to the next meeting of the group to discuss different political strategies that might work. He also referred Bruce to a friend of his who worked for one of the county supervisors interested in public transit. This gave Bruce access to the formal decision-making system. As Bruce began to self-advocate, not only did he start to feel better about himself, but he was making a contribution to the larger disability community. He began to apply his understanding

that his problems extended beyond himself to the social system and societal institutions.

SUMMARY

Six principles guide our approach to working with persons with disabilities. First, we assume that people are capable or potentially capable. Second, we reject traditional methods of practice that assume that the problem with disability lies with the person and that individuals with disabilities must change or be “fixed” before they can function adequately in society. Third, we believe that any model of practice applied to work with persons with disabilities must assume that disability is a social construct and that the primary emphasis on intervention must be political in nature. Fourth, we believe in an identity and culture of Disability. Fifth, although persons with disabilities experience oppression, we strongly believe that there is joy to be found in disability. Sixth, we believe that persons with disabilities must be the ones in control of their lives. This means that the consumer controls the professional.

These six principles are the pillars of our practice model. This model rests upon these pillars and upon principles of strengths-based practice and empowerment. Furthermore, we adopt a social model of disability with a consumer-driven model of practice. Our practice model proposes four fundamental functions for the human service practitioner working with persons with disabilities: counselor, teacher, broker, and political activist or advocate. Several roles are involved in these functions. The functions of counselor and teacher are used basically on the micro and meso levels. Brokers function at all three levels, whereas the role of political activist or advocate plays out in the meso and macro arenas.

DISCUSSION QUESTION

Apply the model of practice presented in this chapter to the following scenario. You are a rehabilitation social worker at a major rehabilitation hospital in the Midwest. You have been presented with the following case:

Anthony Mares is a forty-three-year-old male with blindness as a result of a progressive degenerative eye condition. Married, with three children (ages fifteen, thirteen, and six), Anthony worked for twenty years, until recently, as an auto mechanic. His wife, Patty, forty-one, has worked as a homemaker. She has also worked part-time as a billing clerk. The Mares are buying a home in a small community that is twenty-five miles from the city in which your hospital is located. Anthony is depressed over his recent loss of sight. He exhibits a depressed affect and displays anger toward hospital staff, and his wife states he is “rejecting” her. You have been referred to the case because he is causing trouble for staff and because he needs help with discharge from the hospital, which is due to occur in three days.

How would you assess Anthony and his family using a strengths perspective? Compare how you would view working with Anthony from a traditional and a social model of intervention. What are the functions and roles you might use in working with Anthony? Discuss strategies you might use to help Anthony in empowerment.

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