<table>
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<th>Disability as an Issue of Social Justice</th>
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### Module II:

- Historical Perspectives on Disability
- Disability Rights Movement
- Mental Health Consumer Empowerment Movement
- Consumer Perspectives on Mental Health Treatment
- Disability History and Newsmakers
- Defining and Understanding Ableism
- Social Learning Process
- Disabling Attitudes: Stereotypes and Myths
- Mental Illness/Psychiatric Disabilities: Cultural and Media Representations
- Dismantling Ableism: Becoming Allies
Presenter Instructions:

1. Present brief overview of disability history (20 minutes)

- It is difficult to learn about the history of persons with disabilities because so much is unrecorded or has been lost about their lives and accomplishments.
- What can be discussed with some amount of detail is the historical treatment of persons with disabilities.
- The historical treatment of people with disabilities has been a shameful legacy on civilized nations.
- Historically, the approach to treatment can be generally thought of as falling into six distinct time periods that reflect the dominant modes of thinking of the day.

Post the following chart modified from the book *Teaching for Diversity and Social Justice* (1997), and explain each period briefly.

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Constructions of Causation</th>
<th>Societal Perspectives</th>
<th>Treatment</th>
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<tbody>
<tr>
<td>Pre-1800s</td>
<td>Supernatural causes, divine or devil’s intervention</td>
<td>Disabled persons as blessed or damned, thus divine or dangerous</td>
<td>Tortured, killed, ridiculed, sometimes treated with favor if believed to have special powers</td>
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<tr>
<td>1800-1900</td>
<td>Biological cause</td>
<td>Disabled persons as biologically inferior</td>
<td>Hidden away, shunned, displayed as freaks of nature</td>
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<tr>
<td>Early-1900s</td>
<td>Genetic cause</td>
<td>Polluting the races, draining resources</td>
<td>Institutionalization, sterilization, eugenic experimentation</td>
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<tr>
<td>Mid-1900s</td>
<td>Genetics, diseases, war-related injury</td>
<td>Objects of charity, pity, special care, protection, medical treatment, rehabilitation; also war heroes</td>
<td>Institutionalized, sterilized, given new medical treatments, antibiotics, vocational rehabilitation</td>
</tr>
<tr>
<td>1970 – present</td>
<td>Environmental and communication barriers and negative social attitudes</td>
<td>Self-advocates, Civil rights issue, self-determination, and social change</td>
<td>Mainstreaming, community inclusion, citizenship and civic involvement, inclusion in workforce; passage of Legislation (ADA, Rehabilitation Act)</td>
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<tr>
<td>2000 – present</td>
<td>High-risk behavior, environmental toxins, violence, and genetics</td>
<td>Prevention, health risks, draining resources, Civil Rights have gone too far</td>
<td>Courts limit reach of the ADA, people as genetic research subjects, advocates, concern for consumer safety, environmental cleanup, health education, genetic research, and assisted suicide</td>
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For more detail, use the history outline from the book, *Teaching for Diversity and Social Justice*, or look at the history timeline from the website “Disability and Social History” [www.disabilityhistory.org](http://www.disabilityhistory.org) to give examples from each period. The Disability History Museum ([www.disabilitymuseum.org](http://www.disabilitymuseum.org)) also has useful historical information and is a virtual museum designed for educational purposes with a library and curriculum materials.

2. Show video *A Little History Worth Knowing* (25 minutes)

Show *A Little History Worth Knowing* or other video as appropriate. (See video listing at end of the training manual for ordering information.)

Ask participants to correlate aspects of the video with the timeline and periods of thought discussed above.

- What has changed today?
- What has not changed?

3. Discussion (15 minutes)

- What disability issues might be prominent in the early part of the 21st century?
- How will the aging of Baby Boomers resulting in more people with disabilities in the population influence the way we treat people with disabilities?
- Will new genetic and reproductive technologies eliminate disability or at least the birth of disabled infants? What are the implications?
Presenter Instructions:

1. Present on origins of the disability rights movement (15 minutes)

- Prior to the early 1960s, there was very little self-advocacy on the part of persons with disabilities.
- Advocacy organizations that worked on behalf of person with disabilities existed but were generally single-disability-focused, such as the National Federation of the Blind.
- Other disability-related organizations funded by charitable contributions, such as the March of Dimes and Easter Seals, provided treatment and rehabilitation services to people with physical disabilities. These organizations were also involved in prevention campaigns against diseases such as polio.
- Additionally, state and federal government programs offered medical and rehabilitative services through agencies such as Vocational Rehabilitation and Veterans Affairs.
- Realizing that prior medical and rehabilitative approaches had fallen short of meeting the needs of people with disabilities, the need for a new direction was evident to many people with disabilities across the nation.
- The cross-disability self-advocacy movement began to develop and was inspired by the successes of other civil rights movements.
- A variety of specific consumer driven disability movements aimed at changing traditionally oppressive service systems also sprang up during the late 1960s and 1970s, such as the Mental Patients Liberation/Anti-Psychiatry Movement and Self-determination and Deinstitutionalization Movement for persons with Developmental Disabilities.
- Awareness of Deaf Culture, with its distinct language, history, values, and norms, also expanded during the 1970s and into the1980s with demands for better access to educational opportunities and Deaf leadership at Gallaudet. Such early Deaf activism broadened the cross-disability coalition for disability rights and strengthened its commitment to communications access.
- Interestingly, the disability rights movement shared some unique connections to the women’s movement, as both groups were fighting against being defined solely by our biology.
The disability movement, similar to the women’s movement, was in part about the de-medicalization of people’s lives, increased control over bodies, and redefinition of personal and social group identity through a type of consciousness raising called peer counseling.

Borrowing from the lessons and building on the successes of other civil rights movements, the disability rights movement was born. The framework of civil rights seemed an appropriate way to understand and pursue equality and social justice for people with disabilities.

2. Present on development of the disability rights movement (20 minutes)

- In the early 1960s, a man named Ed Roberts, a quadriplegic polio survivor, worked to establish a program for students with disabilities at the University of California, Berkeley.
- In 1962 the Physically Disabled Students Program (PDSP) began on the campus with just a few students who actually lived at the student health services, which provided personal care and other support.
- Over time, the PDSP began to assist students with other activities, including finding housing off campus, and participants began to advocate for changes in the Berkeley community.
- Ed Roberts and a few other disabled students and community members decided that the services available to students should be available to community members, so they established the Center for Independent Living (CIL).
- The Center for Independent Living opened its doors in 1972 and was the first non-profit organization run by and for people with disabilities that was cross-disability in its focus, community-based, and which provided both services and advocacy using a peer-to-peer model.
- Today there are over 400 CILs across the country and many other places around the world.
- CIL was the birthplace of many other organizations that began as CIL programs and spun off to become independent non-profit organizations. Most notable among these organizations is The Disability Rights Education and Defense Fund (DREDF), which has led most of the significant legislative advocacy at the federal level over the last 20 years, particularly the battle to pass the Americans with Disabilities Act (ADA).
- In 1973, Section 504 of the Rehabilitation Act was passed which prohibited disability discrimination in federally funded programs.
- In 1975, The Education for All Handicapped Children Act (Pub. Law 94-142) was passed. Today the law is known as the Individuals with Disabilities Education Act (IDEA) and assures the rights of disabled children to a free, appropriate public education.
- For the next 15 years, efforts toward implementation and enforcement of these important laws were insufficient, and major gaps were identified in the protections they provided.
A series of other laws were passed which afforded people with disabilities some protections against discrimination in housing, air travel, and voting, but the need for a comprehensive strategy was evident.

A broad coalition was formed that crossed disability categories to fight the common battle for equal access, self-determination, and full participation in all aspects of society.

Justin Dart, often called the father of the ADA, embarked on a 50-state tour in which he collected testimony about the realities of poverty, disadvantage, and segregation experienced by many Americans with disabilities. Dart also ignited the spirit of people with disabilities and their allies to mobilize for full and equal rights and an end to marginalization.

In 1990, the Americans with Disabilities Act was passed, offering a broad range of civil rights protections that extended beyond federally funded programs. The ADA prohibits disability discrimination in public accommodations, transportation, communications, government programs, and employment.

During the 1990s, many changes and improvements were realized, but implementation and enforcement was slow and insufficient. Unemployment rates decreased only slightly and many structural and communication barriers remained.

Since 2000, several lower court and Supreme Court decisions have weakened the ADA, and there is deep concern that a backlash is underway and that slow erosion of the law has begun.

3. Present on the future of the disability rights movement (10 minutes)

Many issues remain unresolved by the years of legislative and community advocacy, and some new concerns have arisen. Some of these current issues, which are capturing the attention of disability rights activists and the nation, include:

- Managed health care and affordable drug coverage
- Access to safe and effective mental health care and availability of self-help alternatives
- Physician-assisted suicide
- The Human Genome Project and genetic discrimination
- Costs and responsibility for special education
- High unemployment rates among persons with disabilities
- The continued fight for self-directed community-based services, such as home care and personal assistance services
- Web accessibility and access to assistive technology

4. Discussion (20 minutes)

- What changes do you think have increased inclusion of people with disabilities in society?
- How have the changes affected your lives? How have you benefited as a “temporarily able-bodied” individual?
➢ What is the most important barrier to full participation in society that you believe still needs to be addressed?
➢ How will the resolution of the controversial issues and availability of supportive services personally affect you now or in the future?
Topic: Mental Health Consumer Empowerment Movement

Goal: Increase understanding of various perspectives on mental illness, mental health treatment, and consumer-run alternatives to the mental health system.

Time: 40 minutes
Materials: None
Preparation: Presenters should review materials from various mental health consumer websites such as National Empowerment Center, or read a book such as *On Our Own*, by Judi Chamberlin.

Presenter Instructions:

1. Lecture on definition of Mental Illness and Psychiatric Disability (10 minutes)
   - Many definitions of mental illness or psychiatric disability exist and there are many theories about their causes. However, the cause of many mental health disorders is still unknown. Although the following factors have been suggested as possible causes, research has not definitively shown that these factors directly cause mental illness:
     - genetics
     - chemical imbalances in the brain
     - abnormalities in the brain’s structure
     - damage to the central nervous system, such as a head injury
     - extreme stress
     - viral infections
     - exposure to violence
     - family dynamics
   - Some schools of thought embrace a medical model, that mental health problems are disorders of the brain that are biologically-based or have at least some biological component.
   - Genetic factors are also considered to play a role in certain types of mental illnesses, and research in this area is increasing.
   - Environmental factors, such as family problems, stress, and poor living conditions, contribute to mental health problems.
   - Trauma is also recognized as a common cause of mental health problems, some serious and chronic enough to be considered a mental illness or disability. Some also believe that trauma causes biological changes in brain chemistry that result in depression, anxiety, and dissociation, etc.
   - In addition to biological, genetic, trauma, and environmental theories, many believe that normal social, psychological, and emotional difficulties are inappropriately pathologized and labeled as mental illness or disability.
   - Regardless of the origins of mental health problems, many believe that trauma associated with misdiagnosis and mistreatment at the hands of the mental health system exacerbates difficulties, unnecessarily causing illness and disability.
- Cultural beliefs about mental illness differ widely, encompassing a range of scientific, social, spiritual, and mystical causes.
- Mental health problems are defined for identification and treatment purposes by those in the mental health system in terms of illnesses, diseases, or disorders according to the diagnostic criteria set out in the Diagnostic Statistical Manual (DSM-IV). Diagnostic criteria usually include a specific collection of symptoms, behaviors, functionality, family history, and evidence of biological imbalance. Many people with psychiatric conditions and some practitioners reject these labels as a way of pathologizing human emotions and experiences.

2. Present on Consumer Perspectives of Empowerment and Recovery (15 minutes)

- Critical to understanding mental illness or psychiatric disability is learning about the perspectives of Mental Health Consumers and Psychiatric Survivors.
- Labeled, defined, and controlled by the medical establishment and mental health system, psychiatric survivors, many once incarcerated in institutions, have worked to reclaim control over their lives. Many reject the term mental illness and associate it with a label imposed by the mental health system, while others still use that term.
- A strong anti-psychiatry/mental health consumers’ movement has emerged over the last 30 years built on the common struggle to regain control over their lives, to describe their experience in their own words, and in general to claim an empowered identity.
- Leaders like Judi Chamberlin, Rae Unziker, Sally Zinnman, Howie the Harp, and many others began what was once called the Mental Patients Liberation Movement, an organized effort by ex-patients and some progressive clinicians to fight the tyranny of psychiatry and create self-help alternatives to the mental health system. These ideas are discussed in detail in a book entitled *On Our Own*, by Judi Chamberlin, available through the National Empowerment Center at [www.power2U.org](http://www.power2U.org)
- Some 30 years later, the movement includes a wide coalition of individuals who work to change attitudes, expand mental health coverage, increase self-help and consumer-driven options, and reform the mental health system. These individuals name and claim their experiences living with mental health conditions and dealing with the mental health system in a variety of ways. The following terms of identity reflect the diversity of consumer perspectives. Respect for an individual’s chosen terms is important in working effectively together.
  - Psychiatric Disability or Psychological Disability
  - Psychiatric Recovery (reclaiming control over ones life and well-being)
  - Psychiatric Survivor (survivor of mental health system)
  - Ex-Patient
  - Ex-Inmate
  - Mentally Ill
  - Mental Health Disability
  - Mental Health Disorder
  - Mentally Restored
  - Mentally Recovered
- Person in Recovery
- Consumer/Ex-Consumer
3. Discussion (15 minutes)

- How do you make sense of such varying perspectives on mental illness and psychiatric disability?
- What are your experiences with the mental health system on behalf of survivors and clients?
- What are some of the benefits and risks survivors may encounter when dealing with the mental health system?
- Why is naming and claiming identity so important for survivors with psychiatric disability?
- How would survivor’s self-definitions affect your approach to working with individual survivors?
Presenter Instructions:

1. **Present priority issues from the perspective of the mental health consumer movement (10 minutes)**

   - Explain that there are many issues that are important priorities for the Mental Health Consumer Movement.
   - The Mental Health Consumer Movement strives to address a range of issues affecting consumers, from education to employment, housing, family life, and civil rights. However, their particular emphasis is on reforms to the mental health system and promoting consumer-driven self-help and peer-to-peer alternatives to the mental health system.
   - This discussion focuses on consumer perspectives on four issues related to mental health treatment: involuntary inpatient and outpatient commitment seclusion and restraint, electroconvulsive therapy (ECT), and Advanced Directives.
   - While there is general consensus about some issues, there are differences in perspectives among individual consumers and various consumer groups.
   - Many of these issues involve fundamental questions of personal freedom, self-determination, and human dignity.
   - The resolution of these issues is of concern to all citizens as the laws and treatment systems we shape today may apply to any of us one day in the future.
   - Meaningful resolution of these questions will reflect the extent to which we care about and are responsible for each other as individuals and as a nation.

2. **Lead a group activity to review and discuss consumer perspectives on challenging issues in mental health treatment (20 minutes)**

   Present the following issues and discuss relevant perspectives and concerns. Stop between issues and ask participants to take a minute to write down a few thoughts or questions. Then facilitate a group discussion using the questions provided. An alternative is to ask participants to get into pairs and discuss one issue. Then have pairs present the issue to the group followed by discussion.

   - **Today our discussion will focus on the following four critical issues that are priorities of the Mental Health Consumer Movement:**
**Involuntary Commitment:** Forced treatment can involve involuntary inpatient and outpatient commitment, involving custodial care, mandatory treatment with drugs, and subjection to other forms of treatment as deemed necessary by a physician or the courts. In Massachusetts, MGL 123, Section 12 is the process used to involuntarily commit someone. On February 17, 2004, the state of New York reconfirmed “Kendra’s” law that allows family or friends to petition for commitment when someone is not taking medications or is otherwise perceived as a threat. This law is controversial in that psychiatric survivors feel it was an overreaction by the community without a full understanding of the circumstances that led to enactment of the law.

- **Discussion:** Some people believe that all forced treatment should be illegal. Many believe that involuntary inpatient commitment can leave individuals vulnerable to abuse and dangerous treatments and interventions. Forced or coercive treatment can lead to a distrust of voluntary services and treatments. Many argue that the use of force and coercion violates civil and constitutional rights and undermines the right to self-determination. Objections to outpatient commitment focus on thin diagnostic criteria for such commitment, the threat of inpatient commitment as coercion, and the intrusiveness of establishing and monitoring acceptable behavior. Some consumers believe that there are extreme circumstances under which individuals should be treated for “their own good” or to prevent them from causing harm to others. Those supporting inpatient or outpatient commitment believe that evidence of potential harm must be tangible and imminent.

**Seclusion and Restraint:** Seclusion and restraint involves several methods that isolate individuals and/or restrain them for short or extended periods of time often with very little observation. The stated intention is to help people regain control of behavior or to protect them from harm to self or others.

- **Discussion:** The use of seclusion and restraint are seen as outmoded and dangerous forms of treatment reflective of the inadequacy of mental health care. There is significant consensus in the movement that the practice of seclusion and restraint should be outlawed. People have died or been seriously injured while isolated or in restraint, and it is often inappropriately used punitively for behavior that is unacceptable to staff. State and federal regulations are increasingly being put in place to govern the use of seclusion and restraint, requiring for example that a staff person is always present and establishing time limits. Staff shortages can compromise consistent implementation of such regulations, leaving patients vulnerable. For example, Deaf women who need to sign are particularly vulnerable if their hands are restrained. Some believe that voluntary restraint and seclusion should be allowed, i.e., restraint and seclusion when requested, but conducted in a way that provides informed consent and right of refusal and which maintains confidentiality and privacy and safeguards for patient safety.
ECT: Electroconvulsive Therapy (ECT) involves sending electrical currents to portions of the brain to treat depression and other forms of mental illness.

- **Discussion:** Many people in the movement oppose ECT, citing its potential to cause memory loss and other types of lasting brain injury. Some people believe ECT should be banned completely, while others believe it can be helpful in extreme circumstances. At a minimum the movement calls for a ban on forced shock treatment (ECT), truly informed consent prior to performing ECT, and an emphasis on aggressive efforts to identify and develop alternatives to ECT.

Advanced Directives: Advanced directives are a way to specify, in advance and in writing, how people want to be treated if illness, including mental disability, makes them incapable, or deemed to be incapable, of making choices.

- **Discussion:** There are two primary forms of advanced directives. The first is Health Care Proxy, or durable power of attorney for health care, which names a person who is legally empowered to make treatment decisions when someone is deemed unable to make such decisions for themselves. The second is a living will, a written document that states, in advance, what treatments someone would want and not want if they were deemed legally incapable to express their own choices. Concerns about advanced directives are that they may be misused if entered into under coercion, when the proxy is not able to handle decisions that need to be made, when directives are inappropriately used to gain control over an individual, or when established directives are difficult to change. It is important to make sure that advanced directives are entered into only through an individual’s free and informed choice.

3. **Discussion (30 minutes)**

Facilitate a discussion with the entire group after presentations are concluded using the following questions. Additional information for participants who want to learn more about these issues is available on the web simply by searching for any of the key words. A particular website of interest is that of the National Empowerment Center at [www.power2u.org](http://www.power2u.org).

- What are your thoughts about the issues presented?
- How do you think they might affect your life?
- How might these issues interfere with individuals seeking help from rape crisis centers or shelters and related domestic violence services?
- How else might they come up in your work with clients?
- What kind of support or resources would you need to assist a client who has faced or is facing these issues?
- Is a community response needed? If so, what kind of action can be taken?
**Topic:** Disability History and Newsmakers

**Goal:** Familiarize participants with recent events and issues facing the disability community and the nation.

**Time:** 50 minutes  
**Materials:** Handout #6 – Disability History Makers Quiz and Answer Sheet  
**Preparation:** Review and photocopy handout. Become familiar with persons listed and their stories.

**Presenter Instructions:**

1. **Present issues facing the disabled community and our nation (10 minutes)**

   - Explain that similar to other movements, the fight for disability rights is ongoing.
   - Passage of the ADA was not a panacea for all the problems facing disabled people across our nation, nor did it eliminate all threats to the wellbeing, self-determination, and survival of people with disabilities.
   - Implications of assisted suicide, abortion, the discovery of the human genome, cloning, managed health care, the growing baby boomer population, and related questions of resource allocation on the lives of people with disabilities and our nation are only beginning to be understood.
   - Some of the people and figures in the following list reflect both the accomplishments of the last 10 years and the many controversial issues that are likely to follow us well into the 21st century.
   - While many of the individuals on the list are white, reflecting the early leadership of the movement, people of color are emerging as important leaders and influencing the agenda and future direction of the disability movement.

2. **History maker identification treasure hunt (20 minutes)**

   - Hand out a sheet to each participant with the names of history makers and ask them to identify each person’s significance and at least one thing that makes them notable.
   - If participants cannot identify the people on the list and their significance, they may move around the room to find one or two other people who might have more information.
   - When the participant finds someone who thinks they know something about a name on the list, they can collaborate to gather as much information as they can and make a few notes in the blank space beside the name.
   - Allow about five minutes for participants to mingle while looking for information about the names on the handout.
   - When everyone has returned to their seats, review the list and ask participants to explain who each person is and his or her significance. If no one knows, then the facilitator should supply the answer from the descriptions on your list.
3. Discussion (20 minutes)

Ask participants to consider the following questions:

- How easy was it to find out who these people were and their significance?
- Were any of the people familiar and if not, why don’t we know more about these individuals?
- Which people stood out or were most interesting to you?
- Which individuals on the list would you most like to learn more about?
- How might some of the listed people’s actions or stories touch your life?
- Are there other individuals, particularly people of different racial and ethnic backgrounds and those representing different disability groups, that you might add to the list?
Presenter Instructions:

1. Introduce ableism as an issue of oppression and social justice (5 minutes)

Briefly explain that this activity will provide a conceptual framework for understanding oppression that forms the basis for a definition and discussion of ableism. This presentation is based on the following assumptions:
- Ableism is a form of oppression affecting people with disabilities that operates much like racism, sexism, heterosexism, etc.
- In order to discuss ableism it is important to first develop a working definition of oppression in the broadest sense.

2. Presentation: Definition and framework of oppression (20 minutes)

Hand out or post the following definition of oppression, adapted from the book *Teaching for Diversity and Social Justice*, on the wall or blackboard. After reading it to the group a couple of times, discuss components as unique factors that work together to create and put oppression into action in our society. Write out or highlight each of the components as you progress and give a general example for each component of the definition. Explain that this general definition will be related specifically to ableism later in the discussion.

**Definition of Oppression:** “A systematic form of domination that is multi-dimensional, complex, pervasive, and operates hierarchically on individual, cultural, and institutional levels and results in social and economic discrimination, disenfranchisement, and exclusion of target or subordinate groups.”

- **Domination:** Oppression involves a dominant group establishing and enforcing beliefs, norms, and values on target or non-dominant groups in systematic ways. **Example:** Christian holidays are celebrated by allowing time off from work while non-dominant religions in the U.S. are not given such broad social recognition.
- **Multi-dimensional:** Oppression is multi-dimensional, with many variations such as racism, sexism, heterosexism, religious oppression, and ableism.
- **Complex:** Oppression is complex in that aspects of privilege and disenfranchisement sometimes coexist because people have multiple social group identities. **Example:** a
white man who is gay may experience privilege as a man, but be discriminated against because he is gay. He may experience more economic privilege by having more opportunities to work than women, but risk being fired if his employer learns of and disapproves of his lifestyle.

- **Pervasiveness**: Oppression is pervasive in that the many forms of social inequity are woven throughout the fabric of our social institutions and have become embedded in individual consciousness. **Example**: Racial stereotypes have led to routine profiling of certain targeted groups by law enforcement agencies across the country, resulting in higher rates of arrest specifically among racial minorities.

- **Exclusion and Disenfranchisement**: Oppression limits possibilities and potential by imposing structural and material constraints on target or non-dominant groups. **Example**: People of color are less likely to be able to own a home due to racial bias in mortgage lending.

- **Hierarchical**: Oppression involves hierarchical social structures and relationships in which one dominant group has power and enjoys certain privileges and benefits often at the expense of other disempowered or non-dominant groups. **Example**: White men have greater access to progressive career opportunities when women are encouraged to stay at home and raise children, thus staying out of the workforce and out of competition with men.

- **Internalized**: Oppression involves a process of internalization in which target or non-dominant individuals or groups may come to internalize oppressive ideas and beliefs about themselves and others. **Example**: The high rate of suicide among gay teens reflects internalization of negative beliefs about being gay, usually combined with rejection from friends and family and hopelessness about the future.

3. **Discussion of ableism as an issue of oppression and social justice (30 minutes)**

Revisit each component of oppression described above and ask participants to offer another example after each point that relates to persons with disabilities to show how the experiences of persons with disabilities meet the definition of oppression. Give examples if participants need them. Revise the definition of oppression, taking out the words “target or subordinate groups” and inserting “person with disabilities.” Explain again that by looking at how the experiences of people with disabilities relate to the definition of oppression we can begin to see that ableism is an issue of oppression.

Ask participants to look at these additional components of the definition to see how oppression and ableism operate on different levels.

- **Levels of Oppression**: The definition states that oppression “operates on individual, cultural, and institutional levels...” Give an example of each level and again ask participants to give other examples.
  - **Individual**: Person without a disability assumes, without asking, that a friend in a wheelchair would not be able to participate in a sport or recreational activity.
• **Cultural**: Placing higher social value on specific kinds of beauty or forms of intelligence over others and using those values as a basis for excluding people from participation in social, work, or educational activities.

• **Institutional**: Denying citizenship to people with disabilities from other countries who are not economically independent.

• **Effects of Oppression**: The definition also states that oppression results in “social and economic discrimination, disenfranchisement, and exclusion.” Give examples or build on examples already provided. Ask the group for examples.

• **Unemployment Rate**: The unemployment rate among people with disabilities is three times higher than that of people without disabilities.

• **Voting**: Persons with disabilities are often unable to exercise their right to vote due to the inaccessibility of polling places and ballots.

• **Adoption**: Persons with disabilities are routinely denied the opportunity to adopt children without conducting an individualized assessment.

4. **Discussion (10 minutes)**

➤ Ask participants if they have any final questions or comments on what has been presented.

➤ How does disability oppression relate to other oppression issues?

➤ What are the similarities and differences?

➤ In what ways is disability oppression a concern to persons without disabilities?
**Presenter Instructions:**

1. **Present definitions of prejudice and the cycle of socialization (20 minutes)**

Begin by posting the following definition of prejudice from the Merriam Webster Dictionary.

**Prejudice:** “An adverse opinion or learning formed without just grounds or without sufficient knowledge. An irrational attitude of hostility directed against an individual or group, a race, or their supposed characteristics.”

Distribute the Cycle of Socialization, developed by Bobbi Harro, and ask participants to follow along as you read aloud and review how the cycle works. Explain that we are born into the world without prejudice but are socialized directly and indirectly to view the world in certain ways. Give examples along the way that relate to different issues, as well as ableism. Explain that the cycle of socialization prepares dominant and non-dominant individuals to play their role in an oppressive social system unless they have the opportunity to become aware and choose another path.

Discuss the meaning of the word prejudice and ask for examples. Differentiate prejudice from oppression by explaining that prejudice contributes to oppression, but remind participants that oppression is much more pervasive and complex than a simple prejudicial attitude or idea. Most importantly it is the presence of power to enforce prejudice that leads to oppression. Thus it can be suggested that:

**Prejudice + Power = Oppression**

**For example:** A white person with prejudice against people of color would, in most places in this country, have the power and social support to act on that prejudice with little or no consequence. At the same time a person of color may have prejudice toward white people, yet would be unlikely to have the power to act on those beliefs without significant consequence.

**Ableism Example:** A person with a disability in a group home may not like their non-disabled caretakers, but must be silent or risk mistreatment or abuse. People without disabilities set the rules for people with disabilities and can enforce them using
punishment, such as limiting privileges or mobility, with the full support of the service system.

While persons from the dominant groups, such as men, may be hurt by actions taken out of prejudice in a specific situation, they are not oppressed. Oppression describes the more over-arching and collective power that a dominant group has over members of the non-dominant group through enforced systems that employ broad economic and social sanctions.

2. Discussion (10 minutes)

- Invite participants to ask questions or comments.
- How does this presentation help us think differently about the experience of disability in society?
- How can a better understanding of disability oppression help us to take action to make change?
Presenter Instructions:

1. Introduction and review (5 minutes)

Begin the exercise by reminding participants about the cycle of socialization (Handout #7 – Cycle of Socialization).

- Myths and stereotypes that are learned as we become socialized shape our ideas and images about people with disabilities. Give a couple of ableism examples to reorient participants to the cycle of socialization.
- Remind participants that we initially come to these constructed ideas innocently and without intention to harm. We hear them all around us and are taught by people who believe they have our best interests at heart.
- Stereotypes often develop from observed behavior on the part of an individual or some members of a group. However, that behavior is then misunderstood, misinterpreted, or exaggerated and is generalized to all people from that group. Stereotypes, even those thought to be positive, are hurtful because they prevent people from being authentically known and judged individually.

2. First Thoughts Brainstorm Exercise (20 minutes)

Ask participants to engage in a “first thoughts” brainstorm exercise in which they are to call out words, phrases, names, etc., that they have heard used in relation to people with disabilities. Read out loud the name of a disability from your prepared list and ask people to call out their first thoughts. Write each word on newsprint or on a chalkboard as they are called out. Repeat out loud each disability several times and move through all the disability categories. The presenter should call out a word or two to get started or to keep the ideas flowing. Then ask participants if there is anything else they want to add to the list. If participants have trouble thinking of words or are embarrassed, reassure them that the point is to get out even the most difficult words or images they have heard. Ask participants to notice how easy it was to make the list and try to pull out any themes, such as variations on the theme of helplessness, being a burden, or being out of control. Notice that some themes cut across disability categories. This exercise can be modified if
desired to focus only on one disability group for a more in-depth examination of stereotypes and prejudice toward that population.

The brainstormed list might include:

different idiot supercrip loony tune hopelessness
helpless deaf and dumb challenged gimp spaz
dependent retard insane lame deranged
burden ugly crazy stupid exceptional
sad child-like tragic abnormal courageous
depressed blind as a bat freak confined special
evil smells suffering condemned inspirational
crippled oddity bag lady admirable dirty
scary weird mental withered restricted
incapable invalid admirable possessed wheelchair-

3. **Show Video Ramp of Hope (30 minutes)**

Show *Ramp of Hope* or other video that might be appropriate to a specific disability on which you wish to focus. (See video section at the end of training manual for ordering information.)

Conduct a discussion asking participants to pick out words, images, and contradictions from the video that reflect stereotypes. This can be done as a large group, in small groups, or in pairs.

- How do the images, words, and stereotypes identified in the brainstorm and in the video reflect cultural norms and expectations? How do they relate to gender expectations for women with disabilities?
- What are the benefits individually and collectively to non-disabled people (members of the dominant group) by maintaining these ideas and images?
- How do these cultural norms and expectations limit all people?

4. **Discussion/Exercise (15 minutes)**

Ask participants to answer the following question by naming concrete actions that can be taken within their sphere of influence. These can be listed on a sheet of paper and examples given presented to the whole group.

- How can we begin to deconstruct and challenge socially limiting images and ideas about people, particularly women, with disabilities?
**Topic: Mental Illness/Psychiatric Disabilities: Cultural and Media Representations**

**Goal:** Recognize cultural messages about mental illness and disability and their impact.

**Time:** 60 minutes  
**Materials:** Handout #8 – Media Portrayal Questions  
**Preparation:** Review and photocopy handout. Collect media portrayals from movies, books, and newspapers and make them available to participants prior to training session.

**Presenter Instructions:**

1. **Present overview of cultural and media representations of mental illness (10 minutes)**

Let participants know in advance that you will be having a discussion about cultural and media representations of mental illness/psychiatric disability and that they should view a film or read a book that has a disability theme prior to the scheduled training session. Select a specific book or film in advance. Have everyone look at the same book or film to allow for an in-depth discussion. Give participants a copy of the questions listed under Participant Presentations later in this section to guide them in preparing for discussion. This exercise can be done focusing on any disability depending on the need for training in a specific area by selecting films appropriate to the disability and modifying the questions as needed.

**Talking points:**

- The media is filled with confusing and often negative messages about people with mental illness or psychiatric disabilities.
- People with psychiatric disabilities are often not described accurately or realistically in the media. Negative images contribute to stigma and the oppression of survivors with psychiatric disabilities.
- Movies, television, and books often play on common stereotypes of people with mental illness/psychiatric disability as either sad, pitiful, in need of our help, or as crazy, out of control, dangerous, or possessed.
- Media images have historically portrayed women who experience sexual assault or abuse as crazy, hysterical, or delusional, using these labels to individually and systematically invalidate their experiences.
- Mental illness is objectified and depersonalized as the media focuses on the “Mentally Ill.”
- News stories sometimes highlight mental illness/psychiatric disability to create a sensation in a news report, even if the disability is not relevant to the story.
- Marketers use words like “crazy” to convey that their prices are unrealistically low and to suggest a shopper can take advantage of them.
- Ask participants to give a few examples of media representations of people with
psychiatric conditions and discuss ways craziness is falsely linked to violence and also used to invalidate survivor’s experiences.

- Have participants also focus on cultural myths about mental illness that extend beyond media presentations to deeply engrained ideas that get passed down. For example: Ideas about attention-seeking behavior and “manipulativeness.”
- Take some time to look at these images and discuss the messages they convey.

2. Participant presentations on Media Images (20 minutes)

Go around the room and ask participants to say what movie or book they examined and to give a brief summary according to the following questions, which you can write on newsprint or give out to each participant as a handout. You may want to give this handout to participants prior to the workshop so they can make notes while reviewing their film or book. Change the wording as needed to focus on a specific disability. Allow 3-5 presentations or more depending on time.

- What was the story about and who were the main characters?
- Was mental illness/psychiatric disability the main issue of the movie, or was it used to add sensation?
- How did people react to the individual with mental illness/psychiatric disability?
- What impressions of the mental health system were presented?
- What words or images were used that stood out?
- What messages does the movie convey about people with mental illness/psychiatric disability?
- What images or messages about women and “craziness” were specifically conveyed?

3. Discussion (30 minutes)

Based on the presentations, ask the group to consider the following questions as they relate to working with survivors with psychiatric disabilities.

- How do these media images create stigma that affects the day-to-day lives of survivors with mental illness or psychiatric disabilities?
- What impact would these stereotypes have when a survivor is looking for a job or housing?
- How could these stereotypes affect staff and residents interactions in shelters, on hotlines, or in support groups?
- How could these stereotypes affect survivors’ access to community services such as police reporting and investigation, testifying as a witness in court, getting a medical examination after an assault, etc.?
- What can we do to challenge our own internalization of these images and gain a more realistic picture?
- Are there positive images from the media that we can draw on to shape a more positive perspective on disability?
How can we make sure we are treating survivors with psychiatric disabilities as people rather than stereotypes?
Presenter Instructions:

1. Introduction and call to action (10 minutes)

Post the following statement and explain that this activity is intended to help people begin to think about how they can be “change agents” for eliminating disability oppression.

Oppression is a result of historically and socially constructed phenomena. Just as it was socially created through collective understandings and actions, so can it be changed towards non-oppressive, more accepting interactions.

- In order to begin working as agents of change against oppression, we must first be able to envision society based on principles of equity and social justice for all.
- We want to work side by side with women with disabilities to develop a vision of what a safe and fully inclusive society would look like for all women.
- We must first develop our ability to be allies to women with disabilities. An ally is a member of the dominant social group who rejects the dominant ideology and takes action against oppression out of a belief that eliminating oppression will benefit everyone.
- It is critically important to begin by making space for women with disabilities to find their voices, to dream, and to create a vision that is true for them.
- People who want to be allies must be willing to truly listen to the needs and desires of women with disabilities as they struggle to define their experience and to respect the leadership of women with disabilities in their battle for empowerment and justice.
- People without disabilities will be embraced as allies by women with disabilities when they show a deep understanding of women with disabilities’ issues and a sincere commitment to solutions that lead to empowerment.
- People without disabilities cannot make women with disabilities overcome the effects of oppression, though they can support, encourage, advocate, contribute and take action as needed.
- With hope, determination and collaborative action we can create a world that values all kinds of people and treats them with dignity.
- Confront and undo your own internalized oppression/attitudes.
2. **Visioning activity (20 minutes)**

Ask participants to give examples of what a non-oppressive, non-ableist society would look like, considering the following questions:

- What would still be here?
- What would be missing?
- What would be new?

Write the answers on newsprint or on the chalkboard. Once a list has been generated, notice the creative ideas that were mentioned and note that this is evidence that we can make changes. Ask participants to also respond to the question:

- What are the costs and benefits to people without disabilities of making these changes?

Finish by listing the following actions that we need to take collectively to make these changes:

- Recover the voices, experiences, and perspectives of women with disabilities.
- Create structures that enhance the capacity for personal development and achievement for all people.
- Resist collusion with the system of privileges and disenfranchisement that foster envy, hatred, violence, and other divisions.
- Expand our understanding of various cultures and their contributions to our society.
- Increase opportunity for economic self-sufficiency and self-determination.

3. **Allies getting started: Personal contracts for action (10 minutes)**

Ask individuals to identify something they can work on as allies to eliminate oppression specifically in the form of ableism and write it on a sheet of paper. Then ask them to write what might get in their way of taking this action and what support they need to follow through. Finally, ask a couple of participants to share all or part of their contracts with the whole group.