

Social Healing: Cultural Change as an Alternative to the Devaluation of Persons with Disabilities

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Social Healing

Cultural Change as an Alternative to the Devaluation of Persons with Disabilities

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Abstract

This article is a discussion of the social consequences of disability as defined by the “18 Wounds” of Wolf Wolfensberger’s (1998) Social Role Valorization theory. With this understanding the authors reflect on how social environments might alternatively respond through cultural change, thereby bringing about social healing in contrast to social wounding. Social healing counters (by preventing, stopping or attenuating) the social consequences of disability experienced by individuals with disabilities, and begins to bring about positive change through a different narrative about the value of people with disabilities enacted in daily practice.

Keywords: *cultural change in the Christian community, social healing, social model interventions, social role valorization, Wolfensberger’s 18 wounds*

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Social Healing: Cultural Change as an Alternative to the Devaluation of Persons with Disabilities

While there are a variety of conceptual models to describe disability, many emphasize the negative experiences of people with disabilities when understood as deviant difference. Across most cultures, times, and places, people with disabilities are consistently devalued. Dr. Wolf Wolfensberger (1998) famously described these “bad things that typically get done to devalued people” (p. 12), or what has come to be known as the “18 Wounds.”^{1,2} He states,

People who are the objects of devaluation, and especially of devaluation of their society, typically have all sorts of hurtful things done to them. Sometimes, these things are done with conscious and explicit intent; sometimes, these things are done unconsciously; and sometimes, these things are simply the result of life conditions and circumstances which are the way they are for the devalued party because of that party’s devalued status and life conditions (p. 12).

These wounds reflect the social consequences of the devaluation of people who happen to have a particular characteristic which is determined as important by those who devalue them. Any characteristic may be selected: people have been devalued based on their gender, ethnicity, religion, socio-economic status, and so on. Here we focus on the 18 wounds as the social consequences of bodily impairment (Wolfensberger, 1972; 2000). Though perhaps obvious, it is critical to note that devaluation is an action, not an intrinsic characteristic of a devalued individual. Individuals within a social environment react to other individuals on the basis of certain characteristics; devaluation is wounding within a social environment that treats those characteristics as negative. We will begin by discussing each of the wounds briefly and then consider a comprehensive response to devaluation that reflects the opposite of a wounding response. This response we will discuss under the term “social healing.”

What Is Disability?

Wolfensberger begins his discussion of wounding by distinguishing between bodily impairment (what he calls **Wound 1**), functional limitation (**Wound 2**), and the subsequent social devaluation of these characteristics (Wounds 3-18). These terms parallel distinctions made within contemporary

definitions of disability that have critically incorporated the social model of disability (Shakespeare, 2010). In its broadest interpretation, the social model states that persons with disabilities are fine the way that they are, and that any difficulty they face is the result of societal discrimination. However, this understanding can be overstated and a bit simplistic. As Shakespeare and Watson (2002) state,

[a]ny individual who had become an activist on the basis of joining a collective united by the social model ideology had a deep investment in the social model definition of disability. “We” were oppressed: “they” were oppressors. “We” talk about disability, we don’t mention impairment. You can’t be a proper activist unless you accept the social model as your creed.... Most activists concede that behind closed doors they talk about aches and pains and urinary tract infections, even while they deny any relevance of the body while they are out campaigning. Yet this inconsistency is surely wrong: if the rhetoric says one thing, while everyone behaves privately in a more complex way, then perhaps it is time to reexamine the rhetoric and speak more honestly (pp. 6-7).

Shakespeare’s honesty is refreshing. However, he is not denying the discrimination that persons face due to their disabilities. He is simply trying not to overstate or claim that the experience of disability can in its entirety be blamed on discrimination.

A “bodily impairment” may include a physical deficit (such as a missing limb), a sensory deficiency, physiological differences in appearance, and mental or intellectual difficulties, among others. These differences might be congenital (the individual was born with them) or adventitious (they developed the differences later in life due to injury, disease, etc.). At times bodily impairments will also result in “functional limitations.” For example, intellectual impairments might result in someone being unable to learn to read or solve algebraic equations. A physical impairment might make it difficult for one to move about the community or engage in some sports. A sensory impairment might exclude someone from being a pilot or a musician. In each of these cases, a real bodily impairment results in a real functional limitation. However, bodily impairments do not necessarily result in functional limitations. For example, both of the authors have visual impairments that are “correctable” with prescription lenses; our visual impairments are largely irrelevant in most circumstances (though our driver’s licenses note our need

for corrective lenses in order to operate a moving vehicle). If an individual with a mobility impairment can utilize a wheelchair—and the physical environment is accessible via ramps or elevators—then the functional limitation resulting from the impairment is minimized.

In this regard, “official” diagnoses can sometimes be confusing. For example, if a person satisfies the assessment criteria to be considered “intellectually disabled,” then they are given that label. However, as a friend who has the label of intellectual disability responded to me (Jeff) when asked if he had a disability: “I am not sure. I have a job. I ride my bike to work. I have an apartment where I live with some help. I have lots of friends. I am not sure if I have a disability.” Would it be appropriate to respond by saying, “I gave you a test and you scored at a particular level, so therefore you are intellectually disabled”? Perhaps a response that describes the specific supports that people need in order to move through their lives, rather than simply assigning a label, would be more helpful. The American Association on Intellectual and Developmental Disability has developed an assessment leading to just this type of description of needed supports called the Supports Intensity Scale (AAIDD, 2019). There is, clearly, a societal or social component to the determination of disability, both in terms of bodily impairment and the degree of functional limitation that can be subjectively determined. Accordingly, a description of needed supports would be much more helpful than a simple label (particularly one that would not be desired by those receiving it).

One might think that the extent of the experience of disability is simply the experience of the functional limitation that results from the bodily impairment and the need for defined supports. If only that were the case. In reality, the remaining wounds seem to flow out of the first two in a cascade of negativity. They largely reflect the social environment’s response to either a label or the need for supports. This is the discrimination alluded to by the social model of disability, and it is what is meant by “the social consequences of disabilities.” These consequences have been conceptualized in an understandable manner in the form of the “18 wounds”; while they have been grouped by writers in a variety of ways, in what follows we consider them individually.

Wounding: The Social Consequences of Disability

Because of my bodily impairment/functional limitation, society relegates me to low social status, because I am considered different from everyone else (**Wound 3**). Societies define what is normal in circumscribed ways, and the slightest variation outside of that normal range is considered deviant.

Because responses to difference can vary from culture to culture, writers describe disability as being socially constructed (Berger & Luckman, 1967). Each culture defines many social aspects of or reactions to life in its own unique manner. For example, in some Middle Eastern societies, women are second class citizens. They are not permitted to go to school or drive a car, among many other restrictions. One might ask, “Is this the reality of who women are?” Clearly not, though the answer is “yes” if you live in that particular culture, because being a woman has been socially constructed in that way. The authors of this paper have traveled to many countries providing training on the issues we are discussing. In every place, people relate how disability has been socially constructed, and almost always in a negative way.

The natural consequence of relegation to low social status is relentless rejection (**Wound 4**). People are acculturated to certain kinds of social interactions in various contexts—we behave according to “social scripts.” When these “customary” relations (McNair & McKinney, 2016, p. 70) are different due to limited social skills or increased demands placed on a potential friendship, rejection of the individual with the disability can be the result. This status can also grow out of the perception (again socially constructed) that disability is the result of bad behavior on the part of the person with the disability or their parents. Disability then begins to travel with shame as a result of this linkage of sin and disability. This has been referred to as the “moral model of disability” (Wasserman, Asch, Blustein, & Putnam, 2011). That is, disability is caused by the sin of one’s parents or family members, or because someone was cursed in some way. This view is actually quite prevalent in many places around the world. People affected by disability—both individuals with impairments and their loved ones—may experience social isolation as a result of rejection. They may also distance themselves by internalizing the shame they have been socialized into believing travels with disability. They withdraw from society in order to escape rejection from the community.

Negative responses to or perceptions of persons with impairments have occurred throughout history. Interestingly, even though many of these responses are not overtly expressed, they are often found “just below the surface.” It may take very little for these responses and perceptions to be drawn out of people. In **Wound 5**, Wolfensberger lists several of these historically based “deviant role perceptions” to bring them to our awareness.² These perceptions of deviancy range from people being considered not fully human, a menace, waste material, as trivium, an object of pity, a recipient of charity, a child, as sick/diseased, or in death-related roles. Several examples of these might be helpful.

Oftentimes, adults with intellectual disabilities will be treated as children. They may act in this way because they have been socialized into acting this way. However, if someone is socialized into being a particular way, that is a reflection of those doing the socialization, not necessarily a characteristic of the person being socialized. For example, we have known adults with Down syndrome who acted and were interacted with like any other adult. When treated in an age-inappropriate manner, they would actually speak up, saying things like “I am not a baby!” On the other hand, we have known other, similar adults with Down syndrome who acted like children and were interacted with as if they were children.

There is also a common perception that persons with disabilities are to be feared. In recent times, this grew out of ideas promulgated in the early 1900’s, such as those expressed in Dr. Ann Moore’s 1911 report featuring her famous admonition to “...realize that the feebleminded are a menace to our present-day civilization and that the problem of caring for them can no longer be safely ignored.... that the defect is often hereditary and incurable, [and] that it leads to poverty, degeneracy, crime and disease” (p. 11). Recently, one of us observed this phenomenon when a group home for medically fragile adults was proposed in the local community. A meeting before the city council was scheduled for public comment. While waiting for an opportunity to speak, some attendees asked whether their children would be safe if these medically fragile individuals were present in the community.

More could be said about these perceptions which have led to people being thought of as sick and therefore “quarantined,” or as being in death-related roles and therefore “better off dead.” These ideas are prevalent, but although people may think them, they don’t typically express them out loud.

Negative labels for people who have disabilities also persist in most places (**Wound 6**). One of us (Jeff) has had the opportunity to speak of these issues in dozens of countries representing many different cultures. In each of these places, he will ask, “Is there a negative term people use in this place to describe persons with disabilities?” The answer is always “yes,” followed by a description of the term and, sadly, an account of how the term might have been derived and is being used currently. Arguably, the use of negative language about people is the first step to negative behaviors toward them. If we are vigilant in speaking out against hurtful language, we may also assist in preventing hurtful behaviors.

But we must be careful about our language even when we think we are speaking positively about someone. Jeff once wrote the following, in his weblog *Disabled Christianity*, regarding the “special” label:

A student of mine, a woman with a physical impairment, recently wrote in an article a synopsis of her experience in her church. The church was one where there were few people with disabilities. She, being largely the only one there, was treated as special, was spoken of as special and anything she ever did was regarded as remarkable because she was special. She wrote of how she tired of this designation, wishing she would just be seen as another regular person attempting to live her life for Christ like anybody else. She has challenges in life, they have challenges in life. She then wrote about how she now attends a different church where many people with disabilities attend, and she is just another congregational member. She is no longer “special.”

The word special is often associated with people with impairments whether it is special education or special ministry. Merriam Webster defines it as “different from what is normal or usual; unusual in a good way: better or more important than others: especially important or loved: more than is usual.” Is that the truth of who persons with impairments are? If it is, then why are we so desperate as a society to prenatally diagnose and abort people with disabilities? If it is not, then why are we being pitifully pejorative and disingenuous in reference to people with a particular characteristic?

The fact of the matter is that special, when associated with an individual, actually implies distance, unfamiliarity, being something other (McNair, 2014).

People can be blamed or “scapegoated” as well. There is the story in an old cowboy novel where the lead character was the son of an outlaw gunfighter. His whole life, he did nothing wrong—but if anything ever happened around him that was in any way wrong or negative, he was automatically blamed because of his lineage. This is the same notion expressed by **Wound 7**. Negative attitudes become self-fulfilling, and rationalizations are seemingly sought out in order to support one’s negative attitudes. An example from a church setting will help provide context. A boy with Down syndrome was in the regular second grade Sunday school class at my (Jeff’s) church. During an art activity, he took the scissors and cut off a piece of hair of the little girl sitting next to him. The “obvious” conclusion was that this boy did not belong in the regular second grade class. My sarcastic response was this was probably the first time that any little boy at church ever cut the hair of the little girl sitting next to him with scissors. The point is that the boy was the victim of pre-existing negative attitudes looking for justification.

We can also see this blaming or scapegoating in more serious situations. Parents of children with disabilities may struggle with the demands of raising their children. There can be additional demands for attention, funding, and time, and these can be severely emotionally draining. Sometimes marriages struggle. Those of us looking on from the outside might be tempted to say things like, “raising a child with a disability can be very difficult. The child with the disability is the reason that family is struggling.” In this way, we do nothing to help—and then blame the child with the disability for the family’s experience.

People will also distance themselves from those who are perceived as different (**Wound 8**). This can be a social distancing, or it can take the form of actual physical distancing. Alternatively, if I am unfamiliar with someone’s personal characteristics, I can choose to get to know that person and the awkwardness will dissipate. Do you realize that when you meet someone who is different from you in some way—say, a person with an intellectual disability—for the first time, generally it is *you* who brings the discomfort to the situation? They see themselves as themselves, living a typical life. You see them as living some different type of reality and because you have distanced yourself from such people in the past, you act strangely when you are around them. The problem is not the initial feeling of discomfort, but rather refusing to break through that feeling so that a relationship can develop. Rather than doing that, we instead distance ourselves from people who are different from us. This enables us to continue along in our stereotypical thinking and our imaginative ideas about who they are (McNair, 2005), rather than having to change—even if that change would be a good thing, both for ourselves and those from whom we distance ourselves.

This distancing is compounded by congregating people with differences together, thereby heightening any characteristics common among them. If I am associated with influential, trend-setting people, I will be perceived as one of them. But if I am grouped with devalued people I will likely experience Goffman’s (1963) “courtesy stigma” (p. 42). That is, I begin to experience the stigma that devalued people experience simply because of my proximity to them. Ultimately, I may experience the segregation that comes with congregating with people with a particular characteristic. Congregation leads to segregation even in “open-minded” people. At a national level, this pattern of “self-sorting”—not only between people with and without disabilities, but amongst other groups as well—has arguably contributed to cultural and political polarization (Bishop, 2009).

Wound 9 describes the experience of people not being invited to friendship. If I experience this wound, my life is filled exclusively or primarily with people who are paid to be with me, such as social workers, group home staff, and day/vocational program workers. No one *chooses* to be with me. Those who *do* spend time with me either have little choice insofar as they are family members (this is not to be critical of family relationships) or they are paid to be with me. Imagine a life filled with only these kinds of relationships.

This is also not to disparage paid care givers. I (Jeff) am a university professor, and I will often relate the following when discussing this wound. I tell my students, “Hopefully, I am a competent professor, a fair and friendly professor. But I am not your friend. The way you know this is that if the university stops paying me, I will stop coming to class!” Now, I do develop friendships with some of my students, which only really begin when class is over. At times we will be having coffee together and I will tell them “I am not paid to be with you right now.” If we haven’t already, at that moment we both realize that we now have moved into a relationship of friendship where we are choosing to be with each other. This is something qualitatively different.

But a pattern of exclusion from relationships seems to be accepted by those in human services. First of all, research has indicated that friendship is not understood by those whose job it would be to facilitate it. Baca and McNair (2013) studied case workers who served with the Department of Developmental Services, a government agency focused on serving persons with developmental disabilities (intellectual disability, autism, cerebral palsy, and epilepsy). They found that these case workers had little understanding of friendship as it relates to the individuals they served, did not know how to facilitate friendships, and were not evaluated on the degree to which their clients developed friendships. In a related article, McMichael-Pierce (2015) surveyed group homes serving adults with developmental disabilities about the community integration of their residents. “Community integration” was understood by these group homes either as activities jointly engaged in by two or more group homes, or as work programs for persons with disabilities. There was virtually no integration with nondisabled members of the larger community. McMichael-Pierce then asked whether any of the homes were ever cited by the state for a lack of community integration. The fact that they were not indicated that the State of California also had no idea what community integration of adults with developmental disabilities entailed. But this is nothing new.³ Amado (1993) reported on a study of integration by Lakin, Burwell, Hayden, and Jackson (1992) which found that “only 5% of the program recipients regularly participated in community activities

with friends who did not have disabilities” (p. 286). Based on this and other research, Amado concluded, “[p]hysical integration does not automatically mean social integration. If people are really to be part of their communities, moving them to small homes is not enough. More efforts and intentionality are needed to promote community relationships” (p. 287). It is no wonder that the lives of people with developmental disabilities are almost exclusively filled with those paid to be with them: the system is not designed to support community integration or facilitate friendship.

Before we move on, one last comment should be made about this wound. Every one of us has the opportunity to do great good in this area. Perhaps the best thing someone can do is to invite another to friendship. This is particularly true of people who have been devalued. If nothing else from this article resonates with you, the reader, let it be this: find someone with a disability and invite them to friendship.

Wound 10 speaks of the loss of autonomy and freedom. This is seen in many settings where there is an interaction between human services and persons with disabilities. We have visited group homes where the residents were not permitted to drink soda, to stay up past 7 p.m., to go to church, to go into the community with friends, to make choices about their diet, or even to watch what they wanted to watch on television. If I happen to have a disability and live in a group home, those who run the home have complete control over my life—an authority that I have never given to them. When one steps into a group home, a list of “client’s rights” is often posted prominently. However, as Zola (1988) has stated, “rights without opportunity [are] meaningless” (p. 23).

The authors once visited a group home for adults with intellectual disabilities. It was Christmas Eve and we dropped by with some gifts and pizza. Imagine our surprise when at 6 p.m. all of the residents were in bed for the evening! Typically, adults don’t choose to be in bed by 6. They were conditioned, by the home, to be in bed at that time. But imagine if one of the residents had said, “There’s a ball game on TV I want to watch, so I don’t want to go to bed till 8:30.” And if another had said, “I’m watching a video and don’t want to go to bed till 9.” What would be the staff’s response? Would you expect the staff to ask each resident what time they wanted to go to bed? Sadly, that would not be the typical response. More likely, a behavior specialist would be brought in to get the residents to comply with the order to be in bed at the time the folks running the home wanted them to be in bed. These decisions are often made on the basis of what is administratively convenient, or on a financial basis (as people in bed require less staff to

manage than do people who are up and active). Providing individual freedom makes demands on those charged with care. Free choices—even those that are entirely appropriate, such as watching a ball game on TV—are often denied because fulfilling them places demands on care providers that they would rather not meet.

Wound 11 is discontinuity with the physical environment and with objects in that environment (“physical discontinuation”). Wolfensberger (1998) describes it as “a very wounding discontinuity with places and physical objects including possessions” (p. 19). Often, group home residents have limited access to possessions. If one visits a group home for adults with developmental disabilities, one might be surprised at how little these individuals actually own. This can explain why these folks are sometimes anxious to receive gifts, as they have very little. A dear friend of mine (Jeff) who lived in a group home would never leave church until I gave him something he could take home with him. These gifts were a potpourri of various items, usually small—but there always had to be *something*.

This wound can also relate to access to and the creation of physical environments. As a reflection of their devaluation, people might be excluded from beautiful places. Jeff once visited Ukraine. While there, he was invited to a quaint old church and taken to a room with intricate wooden carvings on the walls. As he entered, a quintet was playing lovely classical music. It was only then that, as he looked around, he noted this was a concert for persons with very severe disabilities. They were the only people in the room (other than caregivers). This is the complete antithesis to this wound: instead of being excluded from a beautiful setting, their presence in that setting was facilitated.

Wolfensberger describes **Wound 12** in terms of relational discontinuity and abandonment. The article in this volume entitled “Disability as Impaired and Unchosen Relationships” touches on this wound. That article states that the decision to have a selective abortion on the basis of a prenatal diagnosis of disability, for example, is almost always a social decision in that people decide that they don’t want to have a loving relationship with a child having the characteristic called “disability.” People will go to great lengths—abortion, infanticide, segregation, even simply the creation of “programs”—in order to avoid having relationships with people with disabilities. It is not uncommon to meet people with impairments who were abandoned by their families. Many adults who live in group homes also have been abandoned, as they never get visited by anyone. It is interesting how one needs to be only a bit “different” to be excluded by others. This is often the experience of people

with minor social skills deficits: someone just a bit “different” who stands too close, or repeats topics, or engages in some other minor social skill difference may find that that is sufficient for them to be rejected by others.

In **Wound 13**, my perceived “humanity” may actually be reduced. I am viewed as less than fully human because of my degree of dependence upon others, my functional limitations, or the “drain” I am on society, among other things. In this view, to be fully human is to be independent. Dependency is weakness and weakness may imply reduced humanity, particularly in Western cultures. Because people with disabilities are not perceived as being fully human, they experience some of the deindividualization that has been described above. By nature, each human being is unique in myriad ways. To be deindividualized—that is, group-managed and prohibited from being one’s self—takes away freedom.

People who experience severe disabilities may not be able to work. They are therefore dependent on governmental or community support. Others who would choose to work are unable to because of discrimination by the larger society. The authors once spoke about these issues to a group of people in Argentina. One man came forward afterwards who had lost his leg from the knee down when he was a youth, in an agricultural accident. He related that he had not been able to find a job for the past thirty-five years. Why would someone who lost his lower leg not be able to find work? Society can be brutal in its discrimination toward those with disabilities. The result is **Wound 14**: people who are devalued often experience material poverty. But even if they do have material or financial resources, they often also suffer material or financial exploitation perpetrated by others in the social environment—even those charged with providing their care.

One of the many reasons we visit group homes to see friends who live there is to monitor their possessions, which can go missing all too often. I (Jeff) had a friend who loved baseball and lived in a group home. I bought him a baseball glove and would go to his house occasionally to have a catch. Some time had passed during which I hadn’t been able to go to his home. When I went back, his glove was gone. I asked a staff member what had happened to it, and she unapologetically said that she had lent the glove to her son. On whose authority had she felt empowered to do that? Upon asking my friend about the glove, he had no idea where it had gone, and just thought it had been lost. This illustrates, in a small way, the kinds of material exploitation devalued people may experience. To whom would this man appeal about his baseball glove being missing? Because of his disability and the fact that there were other staff members who also were taking advantage

of residents, he would be ignored (at best) or, perhaps, be the subject of “behavioral interventions” (at worst) if his behavior were to escalate over the fact of his missing baseball glove.

When you visit devalued people, you recognize how limited their money and possessions are. But that may also be what is expected when one lives a life supported by “charity.” Why should someone have nice possessions if they are living on public support? This kind of mindset leads to the experiences we see in group homes and other places where people are dependent on governmental support.

Impoverishment is not just a matter of finances and possessions—there can also be an impoverishment of experience (**Wound 15**). Here, because of my bodily impairment/functional limitation, the exclusion I experience from the social environment results in my not having the typical experiences that people have. So, for example, children with disabilities may never have been invited to another child’s birthday party. This is true of adults as well. The two of us have each had the opportunity to expose adults with disabilities to an experience (going to a restaurant, a wedding, the beach or the mountains) for the first time in their lives. On one such occasion, a man with severe disabilities became really excited during a church service when a woman showed up with a baby, because he had never seen a baby before. He stood up, pointing and pronouncing loudly, “It’s a baby! It’s a baby!” Living in socially isolated, regulated settings—where it may actually be difficult for members of the larger community to interact with one (assuming they even want to do so)—can lead to this outcome.

The good news, which we will see later as we address the idea of social healing, is that it doesn’t have to be this way. Those of us who do not experience devaluation can offer participation in typical life experiences: we can have friends who will run errands with us, come over and help with yard work, come for dinner or a barbeque, or visit for a holiday event or Thanksgiving dinner. (We can *be* these kinds of friends, too.) It’s just a matter of invitation.

From a Christian perspective, one of the saddest of the 18 Wounds is number 16. Dr. Wolfensberger was a very devout Catholic Christian, so this wound is not the ranting of some anti-religious atheist. He describes **Wound 16** as follows:

One particular experience from which devalued people may get cut off is knowledge of, and participation in, the religious or spiritual life of society. There are handicapped people who have never really been given instruction in the religion they may have been born into,

nor been permitted to participate in the religious community life of their fellow believers (Wolfensberger, 1998, p. 21).

In this wound, my bodily impairment or functional limitation seemingly gives license for me to be excluded from religious groups. Limited participation in such groups can result in a lack of moral guidance, missing out on the comfort that faith in God might bring, and simply lacking an understanding of who one is in God's social economy. In trainings about disability, we often ask students to do a word association with the word "disability" at the start of a class on disability. Understanding the exercise, they provide words like "loneliness," "isolation," "second-class," "handicapped," etc. These words are associated with disability from a secular societal perspective. We then relate a handful of Bible verses which provide a replacement narrative regarding who people with disabilities are from a biblical perspective. Such ideas include "created in the image of God," "lives with purpose," "not the result of sin," and "indispensable and worthy of special honor," and they replace societally constructed notions. (For some specific biblical passages, see below and the "Towards a Christian Model of Disability" article elsewhere in this volume). Unfortunately, because of their exclusion, particularly from participation in the Christian church community, individuals with disabilities who have been devalued often are never provided the opportunity to see themselves in these biblically based, positive ways.

In a related manner, if those in leadership aren't talking about the experience of disability, this also contributes to the exclusion of individuals with disabilities. Disability is largely not addressed in Christian colleges and seminaries. It is therefore not surprising that leaders' practices reflect exclusion. Their socialization into the role of pastor (for example) has not educated them or provided experiences that would cause them to act otherwise. That is why so many respond with surprise when asked whether people living with disabilities participate in their church: they do not notice the absence of those with disabilities.

A pastor friend of ours from Ukraine once said to us that persons with disabilities are "millionaires of time." This illustrates **Wound 17**, which decries the fact that because someone has a bodily impairment or functional limitation, their lives are wasted. What the pastor implied in saying this is that because these individuals are not being tapped for their potential, their giftings, they have lots of time available. Obviously, this is not always true. But because of the combination of social isolation, discrimination, lack of knowledge on the part of others in society, and limited creativity in

providing options for people to serve, those who are gifted and would love to work, serve, and volunteer instead often have their lives wasted. This is once again a reflection—an indictment—of persons who devalue others, not the individuals who are being devalued themselves. If someone looks at another and concludes they have nothing to offer, they will not take the time to determine what someone might actually be able to do. This finds its way into the public schools, where educational programs for persons with disabilities can become little more than babysitting. It is decided that educating someone is either too much effort or will be fruitless, so no education is undertaken.

Finally, **Wound 18** addresses society's desire to actually end the lives of devalued persons, particularly those with disabilities. We touch on this in our article entitled "Disability as Unchosen and Impaired Relationships," found elsewhere in this volume. Two ways in which people seek to avoid altogether a relationship with a person with a disability is through abortion or euthanasia. We refer you to the aforementioned article for more on these two "options." This life-taking is at times couched as being a humanitarian option for persons perceived as suffering. Yes, people may suffer as a result of some aspect of a disability. However, oftentimes the greatest suffering related to a bodily impairment or functional limitation comes about as a result of the social consequences of the experience of impairment or functional limitation; the article noted above unpacks this in reference to persons with Down syndrome.

A Summary

Taken together, this taxonomy of "18 Wounds" provides a good overview of the social consequences of disability. "Social" is a key word in this phrase. Society is constructed—and anything that is constructed can be changed. It is not that one is asking people who are disabled to not be disabled. Rather, it is about asking all people to not be discriminatory toward others. We have had the opportunity to teach about these wounds around the world. In every place where we have shared this information, people tell us similar stories. Whether it is in Africa, Asia, Europe, North or South America, or Australia, in each place Wolfensberger's wounds are recognized by people in each of these cultural contexts. Now, there may be occasions where a wound does not fully apply. For example, if human services are not well-developed in a particular country, people with disabilities may not in fact have their lives filled (only or primarily) with those who are paid to be with them. However,

the general experience that travels with the wound of people not inviting persons with disabilities to friendship remains true in such cases.

In describing these wounds, Wolfensberger suggests two responses. The first response is to look at oneself and determine the degree to which one is participating in the wounding of others. The point is not initially to critique others, but to critique oneself. This is why I (Jeff) require my university students to memorize the 18 Wounds. As the saying goes, “You see what you know.”⁴ Because people see what they know, it is my desire to share knowledge that will lead to my audience’s perhaps seeing things they haven’t noticed before. If I see something in myself, I am more likely to be sufficiently aware in order to change it.

The second response is to try to prevent, attenuate or stop the wounds from occurring. If I cannot stop them, perhaps I can at least reduce their effect. But what if individuals and communities responded not with wounding, but with healing?

Social Healing

People who experience disability will often say that the social consequences of disability are worse than the disability itself. As Christians, we believe that God in his sovereignty can cure people of their bodily impairments should he choose to. To our knowledge, we have not personally witnessed such a miraculous cure, though we believe such cures can and do occur. However, the biblical concept of healing is much deeper than mere physical cure (most of the biblical words for spiritual salvation and physical cure are the same). Biblical healing has more to do with spiritual wholeness—restoration of *shalom* (peace)—than with changes in physical symptoms: after all, our bodies are all mortal and even physical resurrection such as that experienced by Lazarus is only a temporary reprieve (for more on this in the Gospel of John, see Rhodes, 2016). In fact, many of the New Testament stories of Jesus’ healing those whom we would now refer to as people with disabilities highlight the social aspects of the cure of bodily impairment, the removal of functional limitation, and the restoration of the excluded individual to community (Fox, 2019). We ourselves have seen, facilitated, and participated in this sort of social healing. It is important to note the dual aspects of this healing—one not limited to the individual’s experience of negative social consequences stemming from the social environment, but extending also to a healing of the social environment itself. The individual with a disability feels like something has changed in himself because of the removal of

the negative social consequences of disability. The social environment also “feels” like something has changed: in the language of special education,

[b]y defining the disability as a function of the reciprocal interaction between the environment and the student’s functional limitations, the focus of the problem shifts from being a deficit within the student to the identification and design of supports to address the individual’s functioning within that context with an enhanced focus on adaptations, accommodations, and modifications to the context (Wehmeyer, Tasse, Davies, & Stock, 2012, pp. 11-12).

The changes in self-perception and diminished environmental discrimination are both evidences of cultural change in the social environment. To the individual, the contextual (environmental) change feels like a change internal to her. The context will no doubt feel uncomfortable till the change in interactions becomes embraced as the “new normal.” This is a process that parents and families of individuals with disabilities go through when they realize, for example, that their child with severe intellectual disabilities will not learn to read or go to college or get married. Their expectations for their child change to a new normal where one moves from decrying what someone will not be able to accomplish to celebrating what they are able to do. Similarly, social environments also need to embrace a “new normal” in the same manner that family environments do. This change can be evidenced in the abandonment of socially constructed, negative notions of disability and people with disabilities. These are replaced with new traditions focusing on the prevention, stopping, or attenuation of wounds. Eventually, traditions of celebration can replace old narratives of failure, insufficiency, and deficit. This experience becomes the new tradition, an alternative intuition that replaces the old and leads to a new set of replacement behaviors expressed by social environments.⁵

Just prior to the passage quoted above, Wehmeyer et al. (2012) state, “[d]isability—and in this case intellectual disability—exists only in the gap between those capacities and the demands of the context” (p. 11). We interact with the real capacities of an individual—not those we *wish* someone had, as a result of which we might treat them with a deficit-based response. But rather, the reality of who someone is has moved from being an “unknown other” to being a “familiar friend.” Interactions may not be “customary” (McNair & McKinney, 2016); they may, instead, be simply different: the social environment embraces the “new normal,” this specific kind of difference, and

the cascading positivity (rather than the negative cascading of wounds) that flows out of social environmental change. In social work, this is often described as a “strengths-based approach,” where the most important information is what an individual *can* do, not what they cannot do (Saleebey, 1992)

What might this “cascading positivity” mentioned above look like in a congregational context? We have described this change to the social environment as “social healing.” So, what might social healing look like in the church? As small local communities, the church has the opportunity to demonstrate this. It can begin by responding to people as individuals and by viewing them in terms of their gifts. By facilitating expression of their gifts, there is a greater likelihood that all individuals will be seen as contributing to the larger fellowship. However, as with anyone, their presence is the starting point (1 Cor. 12:22). From there we look for creativity in expression of gifts.

Many of the wounds described have been or are now present in the church. For example, in the area of deviant role perceptions, too many people will treat adults with intellectual disabilities as if they were children, independent of their chronological age. Social healing starts by ceasing to perpetuate these wounds, by resisting negative historical stereotypes. In the next stage, the church can counter these patterns, in this case by treating adults with intellectual disabilities as adults in ways that are appropriate to their chronological age. Adaptation requires adjustment of the environment, not treating individuals inappropriately.

The church can do a great deal to remove the perception of deviancy projected upon people by simply seeking them out and bringing them into the church. In any other context, this would be utterly normal: an intentional strategy of relational engagement is part and parcel of outreach or evangelism activities with other groups of people who are not present in church. Yet people with disabilities, who are often not present in church, are not the focus of such efforts. People with any number of “differences” are often negatively stereotyped when they are not known. When people are known, stereotypes are often dispelled and the projections onto people about who they are imagined to be are replaced with personal experience (Davies, Tropp, Aron, Pettigrew, & Wright, 2011). The Christian community should reflect on its own historical or present stigmatizing of others and model different perceptions through relationships. Friendship is the way to reverse the power of stereotype (Turner & Cameron, 2016).

When a person perceived as different arrives at a church, the community’s response should be to ask, “How can we best love this person?” versus “What are we supposed to do with this person?” Our response should be,

“What can we gain by this person being in our fellowship that we would not gain if they were not here, and how can we contribute to the life of this person God has created in this way and has brought to us?”

People should only be segregated for really good reasons—e.g., because they are a danger to themselves or others. However, sometimes even with the best intentions our initial response is to develop a separate program or group for people. Obviously, not all programs are bad; there can be good reasons for programs or groups. However, if the only involvement in church by persons with disabilities is in the context of a separate group meeting at a time when few people are present, we are complicit in the wounding of these persons, by communicating that we believe segregation—not inclusion—is the appropriate answer to their circumstances. Integration of persons with disabilities into the typical life of the church will cause the typical experience of church to change. It is a corrective. This is something we should expect. It is also something that we should embrace.

In the classic book on friendship, *Friendships and Community Connections between People with and without Developmental Disabilities*, Amado (1993) describes a study which sought to determine what were the two most important areas in which residential staff could assist their clients. They ultimately whittled fifteen items down to two. These were: “1) to help them have more friends, and 2) to help them get along better with people” (p. 284). The church offers great potential for the development of many freely given relationships with persons with disabilities. Friendship development is arguably the most basic—yet the most important—thing that could be facilitated in this context. Churches also typically offer myriad social activities for friends to participate in together. To have a friend call and ask you to do something with him is something that far too many people with disabilities have not experienced. Honest Christian community encourages and extends such invitations to community out of the overflow which we have received from the God we worship (Pohl, 1999).

Autonomy and freedom are important aspects of life that the church community can facilitate. Treating people as adults means allowing them the opportunity to eat too much, to talk too much, to walk around, and just to experience life with less regulation. The first step in this is for the church to advocate for religious freedom in the lives of persons with various disabilities who might not experience such freedom because of the constraints their care providers place upon them in not allowing them even to attend church. It is sad to see restrictions placed on people largely because such restrictions are administratively convenient for care providers. This at-times oppressive

level of control is unnecessary. The starting point is to actually facilitate the expression of one's religious freedom in simply being permitted to go to church. Concretely, this means inviting and providing basic support to enable the acceptance of the invitation (e.g., driving someone to and from their group home to church).

The church offers great potential for participation in ongoing relationships and prevention of abandonment. When a person with a disability comes, he is greeted and welcomed and his name is called. When he is not there, he is missed. Perhaps he has a nickname that causes laughter in those around him but that he embraces. Nicknames are evidence of familiarity, of friendship. Because he is known, people bring him a cup of coffee the way he likes it. These are the marks of belonging.

The Christian community puts teeth in its pro-life position when people with all types of disabilities are present. Even apart from a relationship with such people, they are recognized as valued simply by their presence. As church members develop relationships, they find that people with disabilities are people just like them. Growing up with people with Down syndrome around cannot help but take the fear of Down syndrome from you. It can't help but cause you to second guess the recommendations of physicians pushing for prenatal diagnosis and abortion. The church also needs to be active in speaking out against the deindividualization of people with disabilities, in whatever form it is seen. This advocacy begins with the actual presence of people with disabilities in the church. Lasting advocacy flows from friendship; more than an abstract cause, community is the proof of individual worth.

Even if an individual is financially poor, membership in the Christian community should result in access to the resources of the community. This may take the form of social networks within congregations, for example by connecting job seekers with disabilities to meaningful employment, as the Putting Faith to Work project has sought to demonstrate (Gaventa, Allen, Kleinert, & Carter, 2014). The community has great potential to minimize the impact of poverty. Additionally, presence in the lives of people with disabilities can prevent financial exploitation. The eyes of a friend in someone's life can work wonders.

The kinds of typical experiences most people have should be available through participation in the Christian community. These include dinners out, social outings, service projects and so on. Typically, people will be involved in nonreligious service projects and assist only if they are asked. How wonderful it would be if the range of experiences offered to those who participate in a church broadened for people who chose to engage in them!

From a Christian perspective, one of the best ways to reverse the effects of wounding would be to provide a narrative about disability that is different from that offered by society. This replacement narrative begins by telling people that they are created in the image of God (Genesis 1:26). They learn that their lives have purpose (Exodus 4:11; Psalm 139:13; 1 Corinthians 12:18). They also find that God says that his power is made perfect in weakness (2 Corinthians 12:9). They learn that they are indispensable and worthy of special honor (1 Corinthians 12:22-26). This indispensability is covered in greater detail in McNair (2008). The point for present purposes is that an environment that teaches this perspective should, and would, be reflecting it in its social interactions. A biblical replacement narrative should and would both encourage and direct all who were in that environment. Authentic orthodoxy generates genuine orthopraxy.

Life-wasting is not a reflection of the person whose life is being wasted. It is an expression of the lack of creativity found in the social environment itself. In trainings we have done, Jeff has at times shared how he was guilty of this lack of creativity. It wasn't till he recognized that persons with severe disabilities didn't know how to pray that he began to teach them. They heard the many words by pastors and leaders and when he would ask them to pray they would refuse. The simple prayer of "Help me" or "Help Jeff" opened up a world of powerful service to them. Why hadn't they done this in the past? As their leader, he hadn't recognized their passion for prayer or taught them accessible prayer. Now, rather than being seen as people with nothing to contribute, they are prayer warriors, engaging in one of the greatest things that someone can do for another.

Finally, the church can do tremendous good to reverse the trend toward eliminating persons with disabilities through abortion and other means by having such people present in numbers that minimally reflect their numbers in the community. The church also holds responsibility to speak up in defense of the lives of persons with disabilities and to teach regularly from the pulpit about the value of all life and the Christian's responsibility in affirming that value. Unfortunately, leadership is too often silent on these issues.

Conclusions

What can we conclude from this brief discussion of responses to wounding? First, social healing drives the social environment to be more flexible, as flexible as it can be in overlooking aspects of bodily impairment over

which individuals have no control and for which there is little chance of improvement. These may relate to things like social skills, which one may not have the ability to understand due to their complexity, or because one's impairment makes them unattainable. Perhaps, for example, there are aspects of my appearance over which I have little control; some people might drool—again, for reasons beyond their control. Some are either not habit (toilet) trained, or are physically unable to control their bowels or bladder. We must learn to overlook these differences and see people for who they really are, independent of their individual characteristics taken in isolation. Seeing persons as persons, instead of stumbling over their apparent differences, has been a struggle for Christians from the very beginning. The New Testament is replete with the pastoral challenge of recognizing the work of the Holy Spirit among the Gentiles, as the Spirit incorporated them into the people of God (a category that had previously been understood in strictly ethnic Jewish terms). While all the Pauline epistles address this complex issue in different ways, we turn briefly here to the letter to the Ephesian church for an illustrative example.

The mystery of the gospel in Ephesians 1:9 (and again in 3:3-6) is the cosmic scope of redemption accomplished in Jesus Christ, which means that both Jews and Gentiles are equal. Most contemporary Christians miss the astonishingly offensive sense of this equality, but the reader may begin to appreciate the nature of this claim by imagining whatever group they consider to be “other”—beyond the pale of polite society, someone you would never eat lunch with, invite into your home, or consider a potential friend—for time-honored religious reasons. That group is now equal to you, just as much a part of God's family (your family!) as you are. The early church was riven by conflict about this unwelcome and unlooked-for incorporation, but Paul insisted that Jesus “is our peace, who has made the two groups one and has destroyed the barrier, the dividing wall of hostility” (Ephesians 2:14, NIV). This means that Gentiles are “no longer foreigners and strangers, but fellow citizens with God's people and also members of his household, built on the foundation of the apostles and prophets, with Christ Jesus himself as the chief cornerstone” (2:19-20, NIV). How then should the church live? Paul urges the Ephesians “to live a life worth of the calling [they] have received. Be completely humble and gentle; be patient, bearing with one another in love” (4:1-2, NIV). What does this mean?

Eugene Peterson puts it this way in his translation of Ephesians: “You were all called to travel on the same road and in the same direction, so stay together, both outwardly and inwardly. You have one Master, one faith, one baptism,

one God and Father of all, who rules over all, works through all, and is present in all. Everything you are and think and do is permeated with Oneness. But that doesn't mean you should all look and speak and act the same. Out of the generosity of Christ, each of us is given his own gift" (4:4-7, The Message). All of the "offices" or roles in the church—apostles, prophets, evangelists, pastors, teachers—exist to "train Christ's followers in skilled servant work, working within Christ's body, the church, until we're all moving rhythmically and easily with each other, efficient and graceful in response to God's Son, fully mature adults, fully developed within and without, fully alive like Christ" (4:12-13, The Message). The NIV says: "become mature, attaining to the whole measure of the fullness (*pleromatos*) of Christ" (4:13). In Christ, there is no longer "us" and "them." Union with Christ does not obliterate our distinctions; instead, our differences are divine gifts, ordained talents that are woven together in harmony, like individual players in an orchestra come together in a majestic symphony through the superintending work of the Holy Spirit.

The church's call to maturity in Christ precisely requires our pluriform particularities in order to attain his whole fullness. Insofar as the church does so (even with difficulty or struggle), it displays the glory of humanity fully alive to a watching world baffled by such a contrary culture of unity, mutual support, and fundamental value. The integrity of the church's witness needs people with impairments to use their gifts within a social environment healed (or at least on its way towards healing, through the power of the Holy Spirit) of the wounds of disability. People may well still experience their impairments, but through the countercultural pattern of behavior exemplified in the church, may no longer suffer the social consequences of disability.

If I, as a person with an impairment, inhabit a social environment where change is occurring, I feel differently. If I, as a person with an impairment, am a regular member of the church, its social networks, and various expressions of edification, equipping, and evangelism, I belong. The social environment works with me through the (shared) challenges and inconveniences my disability may present, minimizing the functional and social aspects of my impairment, and together we grow up into the "whole measure of fullness of Christ" (Ephesians 4:13, NIV).

The specific changes that need to occur will vary, ranging from the (social) environment refraining from doing certain things, to the environment beginning to do things or changing the way it does things. The result of this change in the environment is that the person with impairment would find themselves in a place where the social consequences of disability are

lessened, removed, or prevented, and the environment itself is “healed,” in that constituents “do not conform any longer to the pattern of this world, but [are] transformed by the renewing of [their minds]. Then [they] will be able to test and approve what God’s will is—his good, pleasing and perfect will” (Romans 12:2, NIV). As Paul implies, we are in a process of transformation. Transformation is not a once-and-for-all occurrence but a process of maturity and renewal. Tumeinski and McNair (2012) describe this process of self-examination, leading up to the question, “What would be better?” (see article elsewhere this volume). Once the principles for developing maturity and the goal of maturity in a general sense are described, we become aware of how we are maturing in our transformation, in the renewing of our minds. It is comparable to spiritual development individually and corporately. Individuals will grow to no longer reflect the patterns of the world and, if well-lead, the body of Christ as the social environment will also grow to become something different from the larger society. This is a cultural change, a healing of the environment. The environment grows in love. The individual experiencing impairment feels that change, and both the individual and the environment experience social healing. Recognizing that the inclusion of others in the church environment is of such a high value, traditions would inevitably need to change. Church would then look different than it does now.

In Mark 7:1-13 (NIV) there is a telling interaction between Jesus and a group of Pharisees. In verse 5, Jesus is asked, “Why don’t your disciples live according to the tradition of the elders...?” They were asking about the fact that the disciples didn’t ceremonially wash their hands before they ate. Jesus responds by quoting Isaiah, saying “[t]hese people honor me with their lips, but their hearts are far from me. They worship me in vain; their teachings are merely human rules.” That is pretty damning. But Jesus follows up by saying in verse 8, “You have a fine way of setting aside the commands of God in order to observe your own traditions!” He goes on to tell of how in this case, they do not honor their parents. “Thus you nullify the word of God by your traditions that you have handed down.” He concludes in verse 13 by saying, “And you do many things like that.” Their traditions, in this case, did not honor a group of people they should have been honoring. Similarly, there are traditions of the church which contribute to the disablement of people with impairments by resisting (even if unconsciously) environmental change. These traditions must change. Consider the following examples as spurs—or provocations, in a more literal rendering of the Greek *paroxysmon*—to “love and good deeds” (Hebrews 10:24, NIV).

It seems that in conservative American Protestant church culture we have overemphasized the role of intellect in our expressions of faith, discipleship, and growth in faith. As a consequence of this focus, those who experience impairments impacting their intellectual functioning are sometimes excluded from evangelism and efforts to facilitate faith development. One must ask whether this emphasis on intellect is entirely biblical: are the only people who should be the focus for evangelism those with average or above IQ scores? Are reading and intellectual discussion the only ways to facilitate faith development, or might there be other avenues reflected in behaviors that have not yet been fully explored? To quote John the Baptist, “[p]rove by the way you live that you have repented of your sins and turned to God” (Matthew 3:8, NLT).

In recent years, much of the American Protestant church culture has developed groupings of people who are similar in terms of age, interests, hobbies, and so on. This, combined with an unquestioned assumption that public school systems and social services offer the best model for supporting people (especially children) with disabilities, has led to a model of ministry where people are segregated by adaptive behaviors, reading level, location, time, transportation needs, and so forth. A counter to this trend is to insist on mainstreaming (again, drawing on educational theory and practice). But what other models of integration—based on the scriptural depiction of the church as the body of Christ, where the so-called weaker members are indispensable—might be utilized (1 Corinthians 12:22)? What sort of change might arise from restructuring meetings, activities, and worship so that everyone is present, everyone contributes according to their own spiritual gifts, and everyone is valued? Our precedents of practices can change. If they are exclusionary, then they should change.

If we act as “people who honor me with their lips” (see above) and do exchange the commands of God for the traditions of men, then we are guilty of the sins of our social environment. Fill in the blank as to what the particular social environment might be: it could be the school, the restaurant, the church, or the local park. Do our traditions teach us to treat people with disabilities as different from others within our community? Sadly, even when we welcome persons with disabilities into our midst, we may be tempted to embrace a *de facto* hierarchy among them, where they are ranked according to their type of disability (i.e., on the basis of greater or lesser ability, etc.).

Make no mistake: the changes that need to be made so that bodily impairments/functional limitations are no longer social impairments will cause society to change the way it does things. And, likely, the problem is

this: society doesn't want to change the way it does things. Change can be perceived as a burden. One of the greatest challenges to change is the comment, "We have always done things in this way." But the alternative to change is to hold on to discriminatory traditions and practices. That is in part why people with bodily impairments are too often excluded from many social settings. That is probably also why they are not invited to friendships. That is also why ministries are at times segregated so that they are only for people with impairments, and held only at times when no other church members are present. In such cases, the social environment—the church—is unwilling to engage in the kind of creative thinking that would result in programs that cause traditions to change: "And you do many things like that" (Mark 7:13, NIV). We eschew principles of universal design because implementing them would be too much of a "burden" (McNair & McKinney, 2015), and we refuse to invite people to friendship because of the potentially "uncustomary" nature of those relationships (McNair & McKinney, 2016). As a result, we have some churches that are entirely segregated, churches designed just for people with intellectual or other disabilities. Why would a Christian church accept this practice? Because it allows them to continue to observe their traditions, one of which has been the exclusion of persons with disabilities. People who think they are doing the right thing for individuals by providing segregated ministries actually contribute to social wounding, by intensifying bodily impairment through increasing the perception of functional impairment.

It is important to think about the Christian church as a microcosm for social change. Societal change is really difficult. But it might be easier to change one church and then one church and then one church. These changed churches would be an incredible example to the community of how things might be. How might a loving environment improve things for everyone? It demonstrates what is actually possible. People learn about the requirements of being a part of a loving environment. Demands are placed on everyone. Imagine an environment where loving sacrifice is expected of everyone. Government programs can provide a variety of helpful services. But they will never provide the loving care that people need most. In part, then, we might change from dependency on government programs to dependency on people making correct choices about their responsibility toward their neighbors. I learn to depend on you and you on me. The result is healing for the individual and for the social environment. It is one thing to know the right thing to do, and quite another to actually do it.

In biblical stories, Jesus physically cured people and sent them back to their communities for social restoration. Imagine social healing in communities, and people who haven't been physically healed being included in such groups. Physical healing from the hand of Jesus would be incredible! Social healing of an environment that is endeavoring to follow Jesus would also be wonderful. This conversation enables us to picture, in a small way, what the experience would be for all, if we really tried to love our neighbors.

Notes

1. Over time, the descriptions of the wounds have changed somewhat. Those from Wolfensberger (1998) have been revised in recent trainings regarding Social Role Valorization (SRV). This discussion attempts to bring components of the 1998 discussion together with recent information from SRV trainings.

Wolfensberger's social role valorization theory grew out of his revolutionary 1972 work, *Normalization: The Principle of Normalization in Human Services*. If there is such a thing as a paradigm shift in human services, that work was the impetus for this shift.

2. Wolfensberger's "18 wounds" listed together:

Wound 1: Bodily or intellectual impairment

Wound 2: Functional limitation

Wound 3: Relegation to low social status/deviancy

Wound 4: Disproportionate and relentless attitude of rejection

Wound 5: Cast into one or more historic deviancy roles; devalued social status causes devalued roles or vice versa.

1) Non-human

a) Pre-human

b) No longer human

c) Sub-human (animal, vegetative/vegetable, insensate object)

d) Other "alien" (non-human but not sub-human)

2) A menace/object of dread

3) Waste material, garbage, offal, excrement

4) Trivium

a) Not to be taken seriously

b) Object of ridicule

c) Jocular, jester, clown, etc.

- 5) An object of pity—accompanied by a desire to bestow happiness on people and associated with the victim role. The person is “suffering.”
- 6) A recipient of charity
 - a) Ambiguous/borderline object-of-charity role; “nobility” in helping
 - b) Burden of dutiful caring; “cold charity”; entitled to only the minimum; should be grateful “takers,” not “givers”
- 7) A child
 - a) Eternally
 - b) Once again
- 8) A sick/disease organism (leads to handicap); “Medicalization of everyday life”; psychiatrization of deviance
- 9) In death-related roles: dying, already dead, as good as dead, should be dead, should never have lived

Wound 6: Symbolic stigmatizing, “marking, deviancy imaging, branding”

Wound 7: Being multiply jeopardized/scapegoated

Wound 8: Distanciation: usually via segregation and also congregation

Wound 9: Absence or loss of natural, freely given relationships and substitution with artificial/bought ones

Wound 10: Loss of control, perhaps even loss of autonomy and freedom

Wound 11: Discontinuity with the physical environment and objects (“physical discontinuation”).

Wound 12: Social and relational discontinuity, even abandonment

Wound 13: Deindividualization, “mortification,” reducing humanness

Wound 14: Involuntary material poverty, material/financial exploitation

Wound 15: Impoverishment of experience, especially that of the typical valued world

Wound 16: Exclusion from knowledge and participation in higher-order value systems (e.g., religion) that give meaning and direction to life and provide community

Wound 17: Having one’s life “wasted”; mindsets contributing to life-wasting

Wound 18: Being the object of brutalization, killing thoughts and death making

3. In their 1992 article, O’Brien and O’Brien draw the following conclusions about the development of programs by human service providers:

When professional service providers set up a program to assist people who are morally excluded, they often mindlessly follow this recipe: group outsiders together, set them physically apart, isolate them socially, amplify stigma and arouse a sense of differentness, control the details of their lives (often in the name of therapy), enforce material poverty as a condition of assistance, offer relatively greater benefits to those clients who seem more like 'one of us' and lesser benefits to those apparently less familiar, and expect obedience and gratitude in return. Although institutional settings typically express this pattern of denied membership, service reforms often do too (p. 6)

4. This quote, "You see what you know," is attributed by some to New York artist Frank Stella regarding art (see http://www.azquotes.com/author/21931-Frank_Stella). However, we believe it is equally applicable here in relation to seeing the evidences of the wounds as one moves through life.
5. Wolfensberger (2010) expresses concerns similar to those of O'Brien and O'Brien (1992) about the manner in which human services are delivered:

Some core realities and defining characteristics of contemporary western human services, especially in North America and especially to people who are handicapped, afflicted and oppressed.

- 1) Formalization, objectification and bureaucratization of human services.
- 2) Commercialization of human services; both clients and services are commoditized.
- 3) Virtually all services are in essence "technologized," i.e. they rest on manipulation of the material world often even without strong ties to powerful positive value.
- 4) Devaluation of afflicted and distressed people... even servers.
- 5) "Deviancy-imaging" of devalued people, i.e. emphasizing or even enlarging their low value in the eyes of others through relentless attachment of symbolisms with transmit negative messages.
- 6) Services often culture alien and bizarre, e.g. reality orientation with plastic fruit.
- 7) Large scale segregation of devalued people.

- 8) Congregation of devalued people, sometimes in huge numbers.
- 9) Juxtaposition of different devalued groups with each other.
- 10) Severe patterns of restriction imposed on devalued people, often to the point of some form of confinement.
- 11) Disincentives against doing what is right and needed are built into law, regulations, funding, etc.
- 12) The net product of the service supersystem is maintenance of about 1/3 of the population in devalued/dependent/oppressed/impooverished status.
- 13) All of the above is done at phenomenal expense.
- 14) All of the above is done with virtually total unconsciousness of the major realities involved and all of this is disguised/interpreted as good, effective, progressive, etc.

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