The Good Things In Life
2007

WORKBOOK

Name: _____

Objectives:

By the end of this session, participants will be able to:

- identify their own values and attitudes, and recognise those values and attitudes that are prevalent within our society.
- show an understanding of the impact of social devaluation: Life Experiences and Conditions of people who are devalued,
- show an understanding of Social Role Valorisation, and
- identify strategies to assist people with a disability to establish, enhance and maintain valued social roles.

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It is of great importance to have an understanding of what is valued and what draws attention to roles that are and are not valued. Failing to understand this means that people with a disability can end up in roles that are not valued by the community, thereby adding to already existing stigmas associated with people with a disability.

Society has certain values. Different cultures often value different things. We must recognise and acknowledge that in all cultures some people are more highly valued than others. What people value can lead to certain perceptions or assumptions about other people, some of these may be negative.

"Values" are:

- Those qualities of behaviour, thought, and character that society regards as intrinsically good, having desirable results & worthy of emulation by others.
- The beliefs that guide our behaviour and define what is good or bad, right or wrong, correct or incorrect. They make up our belief system.
- Often influenced by our religious beliefs, our family upbringing, our socioeconomic status, our educational background, etc

Our values are influence by our society – including our parents, our peers, the media, etc. There are things that we personally value that most people in our society agree with, these are the values that the society holds in common.

"Attitudes" are:

- The positive, negative or neutral feelings a person has about something
- People's biases, inclinations or tendencies that influence their response to situations, activities, people or programs
- How our values are manifested in our actions and in our thoughts to others

If you have negative feelings about a certain group of people you will react to them in a negative way. The same applies if you have positive feelings about a certain group of people you will react to them in a positive way.

Think about how people react to:

- A group of people with a disability?
- A group of teens in heavy metal clothing?
- Beggars on the street?
- A very beautiful woman?
- The top neurosurgeon in the country?
- A Nobel Prize winner?

Are the reactions positive or negative?

Attitudes are how we show our values and they are a reflection of the wider society or community in which we live.

List some examples of what YOU value? What things do YOU find desirable?

1. _____
2. _____
3. _____
4. _____
5. _____

Our values are influenced by the society that we live in. Different societies will have different things that they regard as intrinsically good or worthy of emulation. Compare our cultural response to older people with that of the Aborigines and their elders.

What does our SOCIETY value?

1. _____
2. _____
3. _____
4. _____
5. _____

Certain people in society hold certain roles. Roles are the characteristics of certain people in relation to their position within society, within family, within community.

List some of the roles that are held by people that are valued?

1. _____
2. _____
3. _____
4. _____
5. _____

Out of the lists that you have made, what qualities do the people you work with have? Circle in a different colour marker.

Does it show that there are few roles or characteristics that have value attached to them for the people with whom you work? This is because people with a disability are often not valued by our society. They do not hold roles that our society values. Many of them fit into what is called 'devalued' roles.

Devalued is, in simple terms, the opposite of valued. Devaluation occurs when a person is seen as being different and the differences are socially significant and negatively valued. (O'Brien 1987 pp.4) Devaluation is about what happens to a

group of people when the majority or most powerful groups in society act negatively towards them.

To be devalued the differences of a group are perceived as negative differences by the majority of society. Reasons why this can happen include:

- people see differences as threatening to them or the people they love – this can result in interpreting behaviours as menacing or dangerous
- a lack of information or education about differences makes people wary and unsure of how to act – leading people to distance themselves from the group
- the strong desire for people to belong to the most popular, most powerful and most valued group – this makes people want to define who does not belong. (reference: Nova employment guide)

Make a list of the types of roles that are generally devalued?

1. _____
2. _____
3. _____
4. _____
5. _____

Devaluation is about what happens to a group of people when the majority, or most powerful groups in society, act negatively towards them.

"The reason for the impact of the stereotypes and the resulting discriminatory laws can be found in the values and prejudices of people in society" (Barton pp 79)

History of services for people with a disability

We can see how society's attitudes towards people with a disability have changed over the last 150 years or so by looking at the history of disability services. The history of disability goes back thousands of years, but since the mid-1800's, there are better records and more significant changes than ever before. An understanding of historical social attitudes will help to understand the current community attitudes and the difficulty workers and service providers have in providing services that meet individual needs and wants.

Brief History Timeline:

- 1800's – large institutions were built to house "defectives". This included people with a disability (idiots, imbeciles, feebleminded), epilepsy, mental illnesses and also prostitutes, vagrants, criminals, delinquents, etc. Prior to this, most people with a disability were cared for at home, in jail or killed.

- The earliest institution for defectives and feebleminded persons in the US was established in Boston by Samuel Howe in 1849. Howe's intent was to educate the defectives so that they could return to society. He was so successful in removing unwanted persons from the streets and from public sight that families and communities refused to have them back. (Barton pp 81)

- In the 1850's many institutions had the aim of teaching those people categorised as "improvable", by the 1880's this changed to just providing custodial care for the 'defectives' and the establishment of farm colonies far from urban areas to protect the retarded and then by the 1900's to 'hospitals' to cure the residents.

- In Western Australia, people with a disability and people with a mental illness were house in the hull of a ship in Fremantle harbour, and in 1857 they were moved to a disused warehouse. The Fremantle Asylum was completed in 1886 (now the Fremantle Arts Centre). Claremont Hospital for the Insane was completed in 1908; by calling it a hospital this indicates the medicalisation of intellectual disability. Montgomery (Superintendent of Fremantle Asylum and established Claremont) requested a "hilltop site so that the cooling sea breezes might disperse those miasmas still thought to cause disease". Claremont Hospital for the Insane was officially opened in 1908 with 700 patients, and by 1920 there were 1100 patients.

- "a reorganisation of Claremont in 1972 divided the section for psychiatric patients from those with intellectual disabilities". (Cocks, Fox, Brogan, Lee, 1996 pp.100).

- planning commenced for the move of *all people* with intellectual disability to Pyrton from Claremont for all the youngest children by 1967 and the younger adults by 1973, this process took time and was <u>not completed until 1984</u>.

- 1975 a North Carolina Statute defined mental defective as: “a mental defective shall mean a person who is not mentally ill, but whose mental development is so retarded that he has not acquired enough self-control, judgement, and discretion to manage himself and his affairs, and for whose own welfare or that of others, care or control is necessary or advisable. The term shall be construed to include ‘feebleminded’, ‘idiot’, and ‘imbecile’. (Barton pp 73)

- Eugenics movement – The Eugenics Movement was a very popular idea from about 1900-1930. And strongly seen during the time of Nazi Germany. It is based on the belief that disabilities were hereditary. The belief was that if feebleminded people were allowed to breed it would dilute the gene pool. This added to the belief that feebleminded people produced a greater number of offspring than the ‘better’ women in society and that the children of feebleminded parents would also be feebleminded. Throughout the world committees were set up to carry this idea forward. Such committees include:

    - The Committee on Provision for the Feebleminded (1915) whose purpose is "To disseminate knowledge concerning the extension and menace of feeblemindedness, and initiate methods for its control and ultimate eradication from the American people", and “the reasons given for the formation of this committee now are the fast awakening interest in the problem of the feebleminded, the realization that present institutional provision for them is utterly inadequate, and the recognition that their presence in the public schools, in correctional and charitable institutions, and at large, is a public menace not yet understood by a majority of people”.

    - Statistician, Ronald Fisher, was very concerned that previous civilizations had collapsed because of the ‘better’ classes had failed to reproduce a sufficient number of offspring. In 1912 he addressed the second annual meeting of the Cambridge University Eugenics Society and stressed the need for careful breeding among the ‘better’ classes. In 1913 addressed the Eugenics Education Society.

    - In 1929 he actively engaged in campaigning to legalise sterilisation. His public opinion was always that sterilisation must be voluntary and must be viewed as a right. He firmly believed that if viewed this way, sterilisation would become widespread and would reduce the number of defectives being born. (Barton pp 80)

    - In 1994 in 3 states in the US, Epilepsy was included as a permissible reason for compulsory sterilisation. (Barton pp 74)

- US – one state had a statute which prevented a man who was epileptic, imbecile or feebleminded from marrying a woman under 45 years of age, the presumed limit of child bearing. A woman under 45 years of age who was epileptic, imbecile or feebleminded could not marry regardless of the man's age. (Barton pp 74)

- 38 states banned or closely restricted the right of a mentally retarded person to marry (1983) (Barton pp 75)

- Parent movement: started when parents wanted more for their children than an institution. Most started out providing education and vocational services for their children. In WA they commenced in the 1950's with Slow Learning Children's Group (now Activ Foundation) and the Mentally Incurable Children's Association (now Nulsen Haven)
- Separation of mental health and disability, late 1970's- at least 12 reports written on services to people with a disability examining poor quality, availability and accessibility. Began to criticize the link between health, mental health and disability. They recommended the separation of health and disability.
- 1985-Individual Statutory Authority established under the Intellectually Handicapped Persons Act 1985 – called AIH (now known as DSC following legislative changes)
- Disability Services Act 1993 (WA) – cutting edge legislation that required services to show outcomes to the consumers rather than the service. (This Act followed the Commonwealth Disability Services Act 1986.)
- 1992: Disability Services Standards – established from the Commonwealth State Disability Agreement (CSDA)
- IF Global: 2005– "Groningen Protocol: advocates legislation on the active termination of life of newborn children with severe impairments. Includes three categories of infants and newborn children: 1) infants with no chance of survival, 2) infants with a very poor prognosis and dependent on intensive care, and 3) infants with a hopeless prognosis who experience what parents and medical experts call unbearable suffering including the prospect of an extremely poor quality of life"

From these examples it is a bit clearer to understand how attitudes and actions can be seen as a reflection of the wider society or community in which someone lives. If a group of people were seen as being a danger to the make up of society by the majority or by a more powerful group, a worldwide acceptance of eugenics, forced sterilization and banned marriages can be seen. Thus, a group of people were seen as devalued.

Devaluation frequently occurs because of differences that people have that they have no control over, such as a disability, their colour, their ethnic/religious background, or their gender.
Devaluation is the basis of SRV, it is about recognising and acknowledging that certain people are being perceived and interpreted by others as having lesser value and taking steps to improve a person or groups perceived value in society. It is also about maintaining and developing socially valued roles.

What are the effects of devaluation?

At its extreme, the consequences of devaluation can be life threatening. . There are certain life impacts or consequences social devaluation. Not all people experience all of these consequences, and even people who are valued can experience some the impacts. However, people from devalued groups often experience more negative life consequences more often. This terminology has recently changed to "Impacts of Social Devaluation: Life Experiences and Conditions" but you may still come across the term 'wounds' and 'wounding'.

However, people from devalued groups often experience more wounds more often.

There are 21 identified Impacts of Social Devaluation: Life Experiences and Conditions of people who are devalued. The first 8 are related to rejection and the remaining 13 related to the loss of control.

1. A physical impairment becomes life defining. It determines ones relationships and often the language used contributes to this; i.e. Person with cerebral palsy is call the spastic or the CP.

2. Functional impairment i.e.; language describes the person – diabetic, head banger, alcoholic
   Again, language can define the person

3. Often these people are relegated to a low social status based on cultural values eg; wealth vs. poverty, young vs. old, unemployed vs. employed.

4. Person may be rejected by community, neighbours, society (all except paid staff) because they need to be cared for by others and also because of fear.

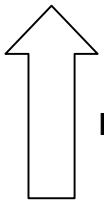
5. May be cast into one of the 6 historical deviancy roles:
   a. non-human = vegetable, animal (implies they behave in a primitive, uncontrolled manner, sturdy furniture, unbreakable windows/TV's, soundproofing, locked areas, barred windows, one way lock doors, fences and gates, no rights,
   b. menace = locked building, staff in uniform, segregating the sexes, removing from the community

c. Object of ridicule = clown, circus, adults behaving childishly or participating in children's activities.
d. Object of pity = 'suffering' from their disability, protective environments, fundraising, donation plaques, logos, underpaying workers, worthy cause
e. Burden of charity = many institutions evolved from charitable homes. Charity sees an entitlement to food and shelter but no frills or extras.
f. Eternal child or Holy Innocent = person considered harmless and treated as a child, using mental age for adults, décor, promoting age degrading activities (visiting Santa), calling them kids, ordering child's portion of a meal
g. Sick/diseased = nurses, medical décor, calling people patients, participating in medical programs (going for a swim becomes hydrotherapy)

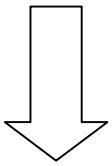
6. Symbolic stigmatising – grouping similar people together, neglecting personal appearance, cemetery near a nursing home.

7. In jeopardy of being suspected of having multiple deviances eg: sick and old, dirty old man, people with disability are sex offenders

8. Distanced by segregation or congregation – uniforms, name tags, separate entrances, off limits areas, separate facilities, lack of access, ignoring presence. Segregating people with a disability can be equally as devaluing as congregating people with a disability, we all know of the 'special buses' – orange with a white stripe.



Related to rejection



Related to loss of control

9. Loss of control – no personal history, dependent on pension, may need to enter a service,

10. Discontinuity with physical environment – moving people often. Often moving to another place due to changing needs or services decision.

11. Relationship discontinuity – 'carers' coming and going, may need to move to receive services, make friends with someone and they move onto another job or place to live

12. Substitute free relationships for paid ones – implies the only people who want to be with you are paid or charitable volunteers.

13. De-individualisation – grouping instead of treating as individual, difficult to differentiate between the needs of the service and the needs of the individual.

14. Material poverty – minimal possessions, no personal possessions – photos, knick knacks, collectables, items of personal interest, individuality

15. Impoverished experiences – have not learnt from experience and impacts on future coping,

16. Spiritual poverty – no opportunity to develop or maintain spirituality

17. Life wasted – low expectations, denied typical experiences, spending hours waiting for activity, lives timetabled

18. Brutalisation and death making – abuse in nursing homes, excessive use of drugs, withholding drugs, moving people into the community with lack of support

19. Awareness of being a source of anguish to loved ones – talking about person in front of them, aged don't want to be a burden

20. Personal insecurity – testing and fantasy relationships, withdrawal, anger, rage

21. Resentment and hatred of privileged citizens

Another point to note with these 21 impacts of social devaluation, is that people can have more than one. Think of a person with whom you work, can you identify any impacts that they may have? How about:
#1 – a physical impairment,
#9 – loss of control
#11 – relationship discontinuity &
#12 – substitute free relationships for paid ones.

A good analogy to understand the impacts is to think of each one as a brick. The more bricks you carry the harder it is. Some people can be carrying so many bricks that they are completely weighed down by them.

So how do we prevent the devaluation of the people that we choose to work with?

Social Role Valorisation

The theory of Social Role Valorisation is what disability services around the world use to guide them in the services they provide. Social Role Valorisation or SRV, as it is commonly referred to, is quite a complex theory and there are courses available to learn about it in greater detail. This workbook will give you a general overview and make it relevant to your everyday work

SRV is a complex theory that was defined by Wolf Wolfensberger in about 1983. SRV evolved out of the theory of Normalisation that was defined by two Danes, Bank-Mikkelsen in 1959 and Nirje in 1967. Throughout the 1970's, Normalisation gained momentum through human services. Unfortunately, choosing a term that most people felt they knew the meaning of was detrimental. Many people interpreted Normalization to mean making people normal and debates continued on what was normal. In 1982, American Dr. Wolf Wolfensberger proposed that normalisation be renamed Social Role Valorisation because "the most explicit and highest goal of normalisation must be the creation, support and defence of valued social roles for people who are at risk of social devaluation. If a person's social role were a societally valued one, then other desirable things would be accorded to that person almost automatically, at least within the resources and norms of his/her society." (Wolfensberger, 1983)

SRV is applicable to any group of people that are devalued, but the majority of the work has been with disability and is just coming to be considered in aged care and other areas.

Having an understanding of what society values, as well as what society devalues, and the affects of wounding, ensures that as a disability worker you are able to identify situations that can have a negative impact on the person you work with.

How do we go about "creating, supporting and defending valued social roles for people who are at risk of social devaluation"?

There are several ways in which people who work with people who are devalued can go about creating, supporting and defending valued social roles. But first there are several themes that are essential to understanding the social theory of Social Role Valorisation.

Themes of SRV

The themes of SRV are of relevance to understanding and applying the theory. As you go through these themes, you should be able to identify where they were discussed throughout this workbook.

1. Unconsciousness: unconsciousness refers to the things that we do without thinking about it. Sometimes these things are so part of us that we are unaware of them. This includes our attitudes and values, as was examined in the beginning. Unconsciousness sustains social devaluation and SRV aims to raise the consciousness or awareness about the issues of devaluation and their impact. Unconsciousness can also explain how society may do bad things to some people while at the same time believing that they are helping them – eg the eugenics movement. As we have seen, a lot of what we learn is unconscious. We learn from many areas including our family, our friends, papers, books and the media.

   Take for example the mother who tells her child not to stare at the person in a wheelchair. She may say this because she is teaching it is impolite to stare, but she may also be teaching her child to avoid people in a wheelchair. Unconsciously, and meaning to do good by teaching her child that staring is impolite, she has taught the opposite.

   The same goes for the media. Take these examples from popular films:
   - These movies portrayed a person with a disability, but were played by a non-disabled actor. Reinforcing the notion of actors with a disability are non-existent or not valued to play the role. (this is a topic of great discussion in the disability community):
     - Rainman (Dustin Hoffman)
     - I am Sam (Sean Penn)
     - Forrest Gump (Tom Hanks)
     - What's Eating Gilbert Grape (Leonardo Di Caprio)
     - Born on the Fourth of July (Tom Cruise)
     - The Other Sister (Juliette Lewis)
   - The 'bad guys' are often portrayed as having a disability:
     - The Fugitive (One Armed Man)
     - Dick Tracy (all the bad guys)
     - Batman Movies (Penguin, Joker)
     - Peter Pan and Hook (Captain Hook)
     - Nightmare on Elm St (Freddy Kruger)
     - X-Men (they're not the bad guys but do live outside of society)

   Unconsciousness also has to do with a low awareness of what devaluation is and the reality of what is happening to people who are devalued. A lack of awareness can lead to further devaluation of the individual without even realising it. SRV aims to ensure that we are aware of devaluation, aware of its impact on the person and aware of strategies to prevent devaluation.

2. Social Imagery: symbols and images that are attached to devalued people influence role expectancies about them and their social value. SRV suggests that people are reliant on signs and symbols to make their decisions. We treat people differently purely because of these signs and images. If people are surrounded by negative images, this will affect our responses to them. Some of the images relate to appearances. A lot of social imagery is unconscious.

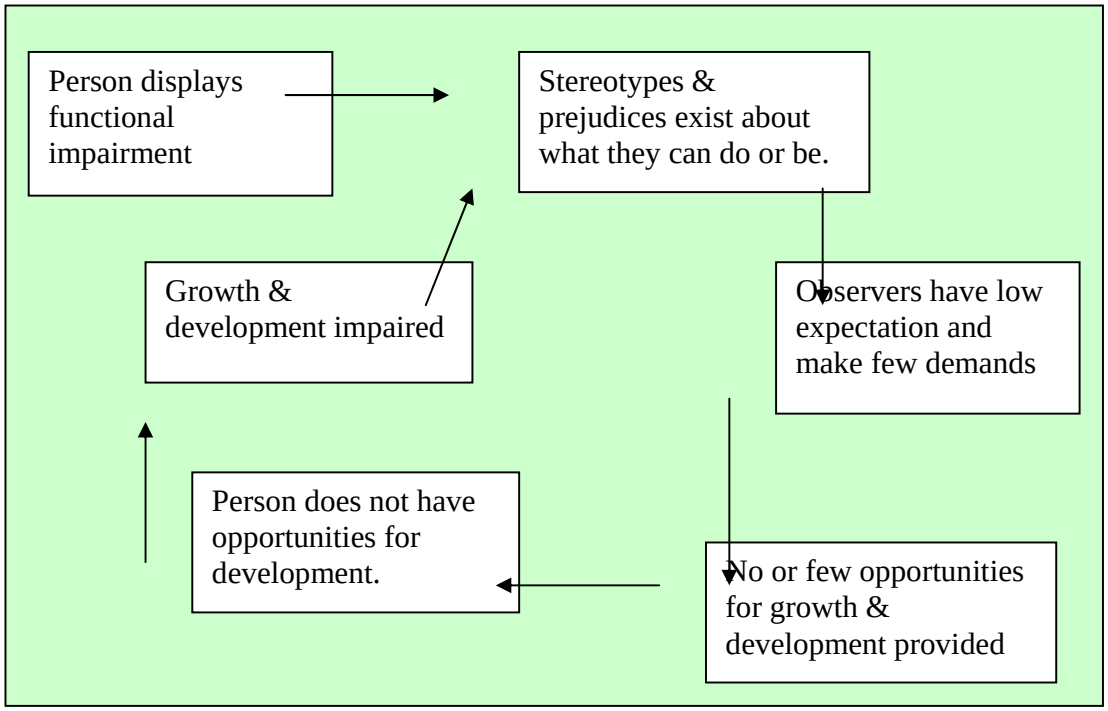
   Think about the images portrayed in these examples:
   - Why were institutions located out of town on a hill? What did this portray unconsciously?
   - What would be portrayed if you saw a group of women with a disability wearing childish clothing?
   - What would be portrayed if you saw a man who uses a wheelchair out with a support person in hospital clothing?
   - What would be portrayed to the neighbours if they never saw the people with a disability that live next door, but they were able to hear them?
   - Think about the image and abilities/competencies portrayed by a dirty, smelly person.

   Being aware of the unconscious imagery that we are promoting (sometimes negatively and sometimes positively), and taking steps to portray positive images, is how workers can improve a persons value within society.

   Factors that influence imagery (positive or negative) to an individual:
   - Nearness to the individual
   - Frequency, number of times it is seen
   - Emotional intensity of the image (eg: snakes)
   - Physical setting of home/buildings (location, appearance)
   - Activities (types of activities, when they occur, routines)
   - Groupings (large or small, with whom, friends, staff, ages)
   - Personal (appearance, possessions, clothing, haircut)
   - Language (names & labels: Johnny vs. John, Numbat Industries)
   - Service aspects (name, logo, funding body)

3. Expectancy: the power of mind sets and expectancies largely control the perceptions of, and behaviour towards, people. Role expectancies and role circularities (self fulfilling prophecies) are among the most powerful social influences and control methods known. SRV identifies the means by which these influences operate (physical environment, juxtaposes, language) and how they can be used to convey positive or negative role expectancies. If we have no experiences with particular groups of devalued people learning and changing, we will not expect people to learn and change. If we do have those experiences, we will expect such changes to occur. Many devalued people occupy roles which have negative expectancies attached to them. Multiple deviant roles may work as a vicious circle leading to further role loss and negative outcomes. SRV develops strategies about how to influence mind sets and expectancies positively.

   In the famous Oak School experiment, teachers were led to believe that certain students selected at random were likely to be showing signs of a spurt in intellectual growth and development. At the end of the year, the students of whom the teachers had these expectations showed significantly greater gains in intellectual growth than did those in the control group. For the moment Rosenthal will venture only one conclusion of a prescriptive nature from his decades of research: "Superb teachers can teach the "unteachable"; we know that. So, what I think this research shows is that there's a moral obligation for a teacher: if the teacher *knows* that certain students can't *learn*, that teacher should get out of that classroom." Pygmalion in the Classroom (Rosenthal 1968, expanded 1992)



A Self-fulfilling Prophecy:
"If we believe you are like it, and treat you like it, you will become like it"

4. Competency and the developmental model: enhancing competencies is reliant on a belief in the developmental model – that all people are always able to change, learn and adapt. Competency enhancement becomes impossible if we do not believe this. Historically, people with a disability were not expected to learn, grow and develop. We saw earlier how society's beliefs inhibited the development of people with a disability throughout history.

   How would you go about improving a person's competencies?

   Improving competencies begins with looking at the individual. What skills and abilities do they have, what valued roles do they have, what are their interests, what valued roles can they acquire, and what do they need to do or learn to be able to be successful in that valued role. It is about creating learning opportunities. Many people who are devalued have experienced wounds that have limited or prevented them from developmental learning opportunities such as learning from experience. We all function daily by recalling past experiences to tell us how to act in certain circumstances, if we have not had those experiences we do not know how to react or act. As workers with people with limited experiences, our role is to offer a wide range of experiences to improve competencies.

5. The effectiveness of services and other interventions: A measure of the effectiveness of service may be made by measuring whether it:
   - is relevant to the needs of the users (relevant),
   - is as intense as possible (potent) and
   - uses a model which addresses the identified need/purpose of the service (model coherent).

   Model coherency refers to the extent to which *what* a service does and *how it does it* fits with the needs of the service users.

6. Relationships between people: Our social identity is a product of our interactions with other people. We build a social identity from the variety of contact that we have with others. Knowing others and having other people value us, can protect us from harm. People who are devalued often have a limited set of people to interact with and often have fewer and less intense real supportive relationships. Access to the 'good things in life' is more likely to be afforded to devalued people if valued people see themselves as being like them and having things in common. If devalued people are seen as being identified with valued people, less harm will come to them.

7. The importance of modelling for learning: One of the most powerful methods of learning is imitation. Much of what we have learned about how to behave is learned by imitation. This is both conscious and unconscious. We are more likely to imitate the behaviour of someone we respect, admire or just feel a kinship to. We also learn bad behaviour by the same process. SRV is concerned with how the dynamics of imitation and modelling, particularly via the grouping and segregation practices of human services, serve to promote socially devalued behaviours. These dynamics can also be used to positive ends.

   For example:
   We often observe how other people behave in unfamiliar situations and follow their lead. Have you ever observed someone and followed their lead when:
   - Going to a new gym class,
   - Ordering at the pub or a cafe,
   - Using new equipment for the first time?

   Many of our behaviours are developed by following someone else's lead, we have all heard of 'lead by example'.

   As workers, it is vital that we lead by example in all of our day to day practices. That includes addressing people appropriately, dressing appropriately for an occasion or work situation, showing respect and privacy within a person's home and generally treating others and their possessions as we would like to be treated.

8. Integration and participation: segregation from valued society is a major wound experienced by devalued people and reinforces negative societal beliefs about those groups. SRV provides a set of rationales in support of the social integration of devalued people in valued participation, with valued people, in valued activities, which take place in valued settings. If devalued people are enabled to become part of society in a fully integrated manner, they are far more likely to benefit from good things in society. By associating devalued people with valued activities or valued people, we are raising their status within their community.

   Congregation can be as devaluing as segregation. Workers need to be aware of the potential impact of congregation and segregation when it comes to working with people who are, or are at risk of, devaluation. One or two people supported to participate in a mainstream activity (Adult Community Education class of twelve) can be much more valued than a group of six people participating in the same class. Workers should seek out the best options when assisting someone to participate in the community. The best options are often reliant on an understanding of the perceived positive value in terms of the type of activity, the support person, age appropriateness, the venue, the timing and other factors.

9. Positive compensation: (the conservatism corollary). Devalued people experience heightened vulnerability in which the likelihood of negative things happening to them, and the harmful consequences of those experiences, are much greater than for valued people. SRV examines this vulnerability and puts forward strategies to respond to it. That is, the more wounds a person has the more vulnerable they are to further wounds. There is a greater need to:
   - prevent additional wounds,
   - reduce existing devaluation and
   - 'bend over backwards' to balance off the devaluation.

   To support people who are devalued, extra effort should be put into finding extra positive attributes to outweigh the negative. When there is a choice of options, the most valued of them should be chosen. Positive compensation is about the extra effort that must be put into overcoming personal deficits in people who are devalued. It is also about being aware of the things that are likely to go wrong and anticipating the alternatives to prevent bad things happening.

   People who are valued usually have the resources (friends, family, competencies) to be able to cope with a wound that they may acquire. People who are devalued, having already experienced wounding throughout their lifetime, may not have the resources to be able to cope with further wounds. The additional wounds may be much more serious and devastating for this individual as compared to people who are valued and acquiring wounds.

   For example,
   An initial wound may be that someone has an intellectual disability; this can become life defining, (the initial impact is: - physical/functional impairment)
   Their family is unable to cope and the individual is placed in a residential facility, (the second impact can include: – rejection by family; and impoverished experiences; and segregation)
   The person is unemployed and reliant on the Disability Support Pension, of which 85% goes to 'the service' and their spending money is the remaining 15%, (the third impact could be: – poverty, loss of control)
   Having no day activity, the person is limited to social contact with the staff that work with them in their home, (the fourth impact could include: – life wasting; and loss of freely given relationships.

   What would happen if now their favourite worker is given a promotion and transferred to another area, or one of the other residents dies, or their home needs renovating and they need to move to another house temporarily????

This person is at risk of multiple wounds. As workers, it is important to again be aware of the wounding a person may have, but to also 'bend over backwards' to prevent additional wounds. Make a list of things that you could do to assist this person to avoid further wounding?

1. _____
2. _____
3. _____
4. _____
5. _____

Some suggestions could include assisting them: to find a job to earn more money, to make friends, to socialise outside of the home, to gain experiences. If they are unable to work, an alternative to employment will also assist them to make friends, socialise outside of the home and to gain a greater range of experiences. Funding could be sought to assist them to join a club with support, to participate in a hobby or to access the community. An independent advocate could help ensure that their needs are foremost in any decision making. A counsellor could assist them to work through any issues they may be having.

Strategies to create, support and defend valued social roles

These 7 strategies are applicable to people who work at in direct care, and also people who work in service planning and development.

1. Defend valued roles: the first process in defending valued roles is to identify which valued roles someone may have.

   Refer back to the roles that you identified as valued – employee, son, student, friend, etc.

   Compare the way it would be if you introduced someone as the person you care for as compared to the person you work alongside. How about the difference between perceptions of a single mother versus a single father? Are single mothers more valued now than they were 10 years ago? How about divorce? Compare our perception as a society to divorce now to that of the 1960's, 1970's or even 1980's? Even the terminology we use today changes the value of a person – the disability industry regularly changes labels from patient to client to consumer to service user and so on.

2. Maintain valued roles: once valued roles are identified for an individual, it is important to maintain those roles to maintain their social value. In employment it is important to assist them to maintain the employment to maintain the role of an employee as compared to someone unemployed. Some of the sheltered workshops make jarrah furniture – a carpenter is more valued than 'he works at a sheltered workshop', even picture framer, clay pigeon maker, cardboard packaging production assistant….

3. Acquire valued roles: You may find it difficult to identify the valued roles of some people that you may work with. It is important to look closely at what valued roles they may have and any skills and interest they have, to identify any roles they may be able to acquire. Identify their likes, interests, hobbies, etc. This can be done by taking the time to get to know the person and their family, and by trialling a range of activities.

4. Re-valorising roles: this one is a little more complex. It is about identifying negative or neutral roles that someone may have and changing them into positive roles. Someone may have an amazing knowledge of movies or music, and it could be possible to create some value in the individual based on their abilities. Unfortunately, re-valorisation can be risky in that you have to be careful not to turn the persons abilities into 'party tricks' thus leading them back into one of the historical deviancy roles (object of ridicule, eternal child)

5. Image and competence management: this is one of the most important ones for workers and a fairly easy one to understand. It is up to the workers to assist people to attain and maintain valued roles. Imagery plays a large part in this as well as competences. Imagery and competency are important *PATHWAYS* to creating a positive image of an individual or group of people. Think about the image portrayed by someone smelly, unshaven and wearing torn and dirty clothes as compared to the same person shaven, clean and in neat tidy clothing.

   Think of the image portrayed of:
   - Someone dribbling,
   - Someone going out with food on their shirt,
   - A dirty and unkempt wheelchair,
   - A support worker wearing a T-shirt with offensive language or pictures,
   - A support worker in a mini skirt and high heels.

   Now consider the support worker (dressed in a pair of clean jeans with a nice top) who carries a small bag with a number of flannels in it to be able to wipe saliva off the persons face on a regular basis. The person's shirt is dry and clean and there is no sign of a bib or flannel on their chest. The support worker may even carry a spare shirt in the bag just in case. The support worker is portraying a positive image of the person with a disability.

   Competencies go hand in hand with this, that is if someone feels good and is rewarded/acknowledged for doing good things or accomplishing things, they are more likely to repeat it. Go back to the unshaven, filthy man. In this role it could be assumed that people in the street would have avoided him, they would not have spoken to him and he would have been rejected. But, if when he was clean, people spoke to him, they acknowledged his presence and he was complimented, there is more of a chance that he would repeat it. As workers with people with a disability it is our role to assist them to understand this and the consequences of their actions or choices. The same applies in the home situation. By treating people as the homeowner, and the worker as the visitor (which they are) people can be assisted to develop a valued role as well as a range of competencies to then be viewed by others as being in a valued role. Assisting people to undertake duties that accompany being a homeowner is vital. This includes cooking, shopping, home maintenance, deciding on what to eat and when to eat.

   It is important to assist the person to attain and maintain a positive image and developing a persons abilities or competencies can assist in achieving this.

6. Role management: this is about managing the social roles. As a worker with someone who is either devalued or at risk of devaluation, it is important to focus on the valued roles they have. SRV is often mistakenly interpreted as to mean forcing people into things they may not be interested in, to attain a valued role. SRV is about identifying the valued roles a person has, or can acquire, and building on them. To have a positive image in the community is being valued as a "local".

7. Action at different levels: SRV is theory that can be applied by intervening at different levels of society to prevent devaluation. As direct care workers, we often only see it at the personal level, that is, with the individual. But in direct care we can also work on the social systems that are in the immediate vicinity of the individual – your family, your friends, your colleagues. The next level would be the places where the person goes and has direct contact with people that they don't know personally (yet). This includes people in the local community such as banks, grocery stores, deli, etc. If people have positive contact with people with a disability they will be more accepting of other people with a disability that they come in contact with in the future. Service providers, government, advocacy services and others contribute to promoting valued roles and acceptance at a larger level.

Wolfensberger (1995) defined an "if this, then that" formulation of decisions related to SRV. That is,
If we are aware of how some people are socially devalued
And
If we know of the common life experiences of people who are devalued
And
If we have a vision for a better life for people who are devalued
Then
We can implement the SRV framework to maintain, develop and defend values social roles for people vulnerable to devaluation.

Summary

As a worker with people with a disability, Social Role Valorisation is the key theory that guides organisations in the services that they provide. Unfortunately, some services could do a lot better. The knowledge a worker has about SRV can go a long way to ensuring the people you work with, as well as all people with a disability, are afforded the good things in life and viewed positively by their community.

The most recent definition of Social Role Valorisation by Dr. Wolf Wolfensberger (1995) is "The application of what science can tell us about the enablement, establishment, enhancement, maintenance, and/or defence of valued social roles to people."

This workbook provides a brief overview of SRV and how workers with people with a disability can incorporate it into their day to day workings. To understand SRV, workers first need to understand what they and their society values (and does not value). Do you value people with a disability? Valued social roles differ within different cultures and something that is valued in one culture may not be valued in another. This ensures that SRV is relevant to different societies and cultures around the world. What we value as a culture is determined by our upbringing, our family, the media (print and film), our friends, our religious beliefs and others. This is very often unconscious and we rarely think about or question what our values are or where they have come from. SRV challenges workers to do this and in turn, provides strategies to ensure that the people with whom we work, which currently are or are at risk of being devalued, are portrayed in a socially valued way.

Strategies to enable, establish, enhance, maintain, and/or defend a person's valued role is by way of:

- Image
- Competence
- Community Life (integration and participation)
- Expectations
- Growth (and development)
- Imitation (and modelling)
- Extra effort

Often workers do not feel that they can contribute to SRV, but workers are the key to implementing SRV practices. It does not need to take time, it does not need to take money and it does not need to take permission. Practices that value the people you are working with should be an assumed part of your role.

Next time you are at work, have a think about:

- The appearance of the people you work with,
- How they are spoken to in the home, in the community, in their place of employment,
- The appearance of the staff,
- Where the people you work with go to recreate, to shop and to socialise,
- How they may be perceived by their neighbours and their community,
- Is there a distinction between staff and service users,
- What terminology or jargon do you use,
- What terminology or jargon to other staff use,
- The appearance of their home or place of employment?

SRV "can help not only to prevent bad things from happening to socially vulnerable or devalued people, but can also increase the likelihood that they will experience the good things in life. Unfortunately, the good things in life are usually not accorded to people who are devalued in society. For them, many or most good thing are beyond reach, denied, withheld, or at least harder to attain." (Osburn, 1998)

Work together to ensure the people you work with have opportunities to enjoy THE GOOD THINGS IN LIFE.

References:

Author unknown (1915). A Committee to Eradicate Feeblemindedness. *The Survey.* Retrieved September 2006 from http://www.disabilitymuseum.org/lib/docs/1777.htm

Barton, L (2006) Overcoming Disabling Barriers: Eighteen years of Disability and Society. Routledge, UK

Cocks, E., Fox, C., Brogan, M., Lee, M. (eds) (1996). Under Blue Skies; the social construction of intellectual disability in Western Australia. Centre for Disability Research and Development, Edith Cowan University, Perth.

Cocks, E. (2001). Normalisation and Social Role Valorisation: Guidance for Human Service Development. *Hong Kong J Psychiatry*, 11(1), 12-16.

Jenkins, P. (1999). Essential Social Role Valorisation. SRV South West, UK SRV Network

Lester, N. (nd). Blue Eyed: A Guide to Use in Organizations. Retrieved September 2006 from http://www.newsreel.org/guides/blueeyed.htm

Little, S. (1912). Letchworth Village: The Newest State Institution for the Feeble-minded and epileptic. *The Survey*. Retrieved September 2006 from http://www.disabilitymuseum.org/lib/docs/1738.htm

Nova Employment (2004) Social Role Valorisation. Retrieved September 2006 from www.novaemployment.com.au/take%203/Docs/SRV_Manual.pdf

Osburn, J. (1998). An Overview of Social Role Valorisation Theory. *The International Social Role Valorisation Journal*, 3(1), 7-12

Peters, M. (1998). Relegated to the back-seat of life: reflections on the losses experienced by a person with a disability. *Inroads*, Citizen Advocacy Eastern Suburbs, issue 7.

Rosenthal, R. (1968/1992). Pygmalion in the Classroom. Retrieved September 2006 from http://www.ntlf.com/html/pi/9902/pygm_1.htm

Thomas, S. & Wolfensberger, W. (1994). The Importance of Social Imagery in Interpreting Societally Devalued People to the Public. *SRV-VRS: The International Social Role Valorisation Journal*, 1(1).

Wolfensberger, W. (1972). The Principle of Normalisation in Human Services. National Institute on Mental Retardation, Toronto.

Wolfensberger, W. (1975). The Origin and Nature of our Institutional Models, Human Policy Press, USA.

Wolfensberger, W. (1983). Social Role Valorisation: A Proposed New Term for the Principle of Normalisation. *Mental Retardation* 21(6), 234-239

Wolfensberger, W. (1995). An "if this, then that" formulation of decisions related to social role valorisation as a better way of interpreting it to people. *Mental Retardation* 33(3), 163-169.

Ziegler, H. (2004). Changing Lives, Changing Communities (Revised edition). Wesley Mission Melbourne, Australia

Further reading websites:

www.socialrolevalorisation.com

www.diligio.com