

## Intersectional Anti-Racist Practice with the Disability Community

Lamont D. Simmons  
University of the District of Columbia

Elsbeth Slayter  
Salem State University

### Abstract

Many intersections exist between communities of colour, the disability community, and other social identity groups. For example, one in four Black or African American members in the United States are disabled. Disability is also more prevalent in queer communities. Yet, social workers in the helping professions rarely make these connections. The application of an intersectional, anti-oppressive, “critically culturally competence” theoretical practice framework for empowerment-oriented work with the disability community is presented. Specific guidance is provided for addressing how social service providers can develop their “disability lenses” in pursuit of anti-racist and anti-ableist practices.

*Keywords:* intersectionality, race, disability, anti-ableism, anti-racism, progressive practice

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### Introduction

Societal discourse demonstrates that racism is the marginalization of people of colour based on socially constructed hierarchies that privilege white people. An anti-racist social worker is one who engages in antiracist actions at the micro, mezzo, and macro levels through their actions, ideas, or practices. To become anti-racist practitioners, social workers can start by wrestling with the idea that all have all been raised in a racist society. Black scholar Dr. Ibram X. Kendi (2019) comments on the ways that often unintentional racism has rained down on all of us and as a result, how can any of us not be racist. Therefore, social workers must start where they are with the systems in which they practice by taking a good, hard, deep look inside themselves. Social workers must consider how a racist society affects our work with clients and colleagues and act on it. While social work as a field is taking a stronger stance on considering racism and anti-racism as it relates to practice, there appears to be less of a commitment to addressing ableism (Slayter et al., 2023). Unfortunately, ableism is often a common experience among people in the disability communities in the West/Global North. So how does racism connect to ableism? It turns out that ableism and racism are strongly related. Kendi, host of the podcast *Be Antiracist* (Kendi, 2021) and author of the book *How to be an Antiracist* (Kendi, 2019), says:

It is pretty apparent to me that one cannot be anti-racist while still being ableist ... I think for many people who are indeed striving to be anti-racist they may not realize the ways in which they're still being prevented from moving along on this journey due to their unacknowledged or unrecognized ableism, or the ways in which they're in denial. (Kendi, 2021, pp. 31–32)

As Slayter and Johnson (2023) note, the disability community is an oppressed and underserved population in the United States due both to disability as well as to their other social identities. Further, these authors also note that for those living with an impairment, life is often flavoured by the experience of facing intersecting oppressions such as racism. When thinking about ableism through the lens of a single oppression, it is important to consider the following: it is “the belief that because persons with disabilities are not typical of the nondisabled majority, they are inferior. Ableism precipitates devaluation, while the results of devaluation, including exclusion, ostracism” and a lack of privilege, can reinforce the attitudes, behaviors, and government actions of those who oppress. Four manifestations of oppression characterize ableism, “containment, expendability, compartmentalization and blaming the victim” (Mackelprang & Salsgiver, 2015, p. 105). Containment refers to the practice of limiting choices, exposure, and life experiences. Expendability refers to the idea that disabled people are unimportant or disposable. Compartmentalization refers to the stereotyping of disabled people in a way that places people in predetermined categories. (Slayter & Johnson, 2023)

As Slayter & Johnson (2023) discuss, disability interacts with all social identities, such as race, ethnicity, religion, gender, gender identity, sexuality, and socioeconomic class (as cited in Hirschmann, 2013). Developing an understanding of the ways that disability discrimination and ableism intersect with other types of oppression is important for social workers to understand when practicing with the disability community. This understanding is especially vital given the history of ableism in the field of social work and the lack of responsiveness evidenced by recent laws (e.g., *Americans with Disabilities Act of 1990*) (Slayter & Johnson, 2023).

Another analysis of ableism that is important for social workers to sit and wrestle with is presented by Talila Lewis (2021), which lifts the ways in which ableism and racism are connected. Their discussion posits that “the root of racism is ableism; and the root of ableism is anti-Blackness” (Lewis, 2019, n.p.). They argue that addressing and rooting out ableism is virtually impossible unless you first address and solve racism. For example, Lewis (2019) says that “ableism is also at the root of every other oppression” (n.p.). This intersectional argument in Lewis’s definition of ableism moves beyond the more traditional definition presented above (Slayter & Johnson, 2023). Lewis (2021) states:

Ableism is system that places value on people’s bodies and minds based on societally constructed ideas of normality, intelligence, excellence, desirability, and productivity. These constructed ideas are deeply rooted in anti-Blackness, eugenics, misogyny, colonialism, imperialism, and capitalism. This form of systemic oppression leads to people and society determining who is valuable and worthy based on a person’s language, appearance, religion and/or their ability to satisfactorily [re]produce, excel and “behave.” You do not have to be disabled to experience ableism. (n.p.)

### **Intersections of Racism and Ableism**

The historical roots of the relationship between racism and ableism are discussed below through the use of four different examples. First, during the period of slavery in the United States, slaveowners conjured up the idea of *drapetomania*, the alleged psychosis that was experienced by runaway slaves that, in retrospect, was emblematic of the interaction of ableism and racism (Kres-Nash, 2016). This is an example of how race is pathologized to create racism. In other words, people of colour were treated in specific oppressive ways in order to create barriers and conditions that resulted in the origination of disability categories. In reflecting on *drapetomania*, Isabella

Kres-Nash (2016) points out that “the concept of disability has been used to justify discrimination against other groups by attributing disability to them” (para. 1). Of *drapetomania* specifically, Kres-Nash says that the idea of drapetomania is an example of a “disability being created by people in power in order to preserve social order,” (para. 2) all of which occurred in a racialized context during slavery.

Second, moving into the 19th century, it is important to consider the popularity of *phrenology*, a pseudoscientific technique originally developed in the late 1700s that purports to determine an individual’s character and abilities (and therefore, alleged superiority) (Poskett, 2013). One’s character and abilities, it was posited, could be deduced from the size and shape of various bumps on a person’s head that would allegedly tell us if someone was less than, therefore, disabled. Phrenology, among other things, was used to justify the practice of slavery, as was depicted in the film *Django, Unchained* (Poskett, 2013). Although this type of pseudoscience has long been discredited, this technique is considered a precursor to modern neuropsychology and appears once in a while in current-day conversations about the use of technology and facial recognition (which is known to be much less accurate for people of colour) (Whyman, 2020).

Third, in more recent times, such as at the turn of the 20th century, the connections between racism and the ableist Eugenics movement (which sought to breed a perfect human race through a form of “scientific racism”) are more apparent (Skibba, 2019). “Eugenics is the belief that human evolution can be crafted by the encouraged breeding of people who are considered the most desirable—the ‘fit’—and the discouraged breeding of those who are considered the least desirable—the ‘unfit’” (Withers, 2012, p. 13). This movement often targeted “feebleminded” people now known as intellectually and developmentally disabled people, among others, for sterilization, many of whom were people of colour (The History Engine, n.d.). In his discussion of the treatment of African American and Black “feebleminded” people, Dorr (2006) says “African Americans had become the targets of extra-institutional and extra-legal sterilizations, reflective of a more general southern racist view that it was necessary to further protect the white race itself from black folks” (para. 3).

Fourth, in the early 1900s, what transpired with the Black and multiracial inhabitants of Malaga Island in Maine is also emblematic of the relationship between racism and ableism. This small coastal island was a multiracial fishing community originally founded by an ex-slave (Milner, 2020). While interracial marriage was illegal, the community allowed people to live and let live. It is said that many of the inhabitants of the island were “feebleminded” or intellectually and developmentally disabled, in current parlance. Whether this allegation is accurate is unknown. As the Eugenics movement gained popularity and as the value of Maine’s coastal islands became clearer as tourist destinations, state government officials issued an eviction order to all the Malaga residents—of all races and ethnicities—citing a range of ableist and other reasons for the action (Field, 2019). All residents who had no place to go were to be placed in the “Maine School for the Feebleminded,” where some were eventually sterilized and lived out the rest of their lives. The price of miscegenation was banishment from a happy community due in large part to ableism (Field, 2019).

Our review of several historical examples related to the connection between ableism and racism above sets the stage for us to consider the present day through several examples. Part of building capacity for intersectional anti-racist disability clinical practice involves exploring the intersections of racism and ableism in the present day. These factors play out historically as well

as currently in the context in which social workers practice with clients. In the US, communities of colour with disabilities have higher rates of unemployment than their white counterparts, for example (United States Bureau of Labor Statistics, 2022). Specifically, “among persons with a disability, the jobless rates for Hispanics (16.8 percent), Blacks (16.3 percent), and Asians (15.7 percent) were higher than the rate for Whites (11.6 percent) in 2020. These rates increased among all major race and ethnicity groups from 2019 to 2020” (p. 2).

Many social workers have seen this intersection in classrooms for decades, with disproportionate numbers of students of colour being referred to special education (Anderson, 2020). Table 1 provides an example of the number of students in one American state’s (Massachusetts) special education classes in 2019 by race and ethnicity compared to the state’s racial and ethnic population prevalence (Fermanich, 2020; U.S. Census Bureau, 2022). The comparison of these percentages, or rates, shows disproportionality as it relates to students of colour.

*Table 1.* Comparison of special education and statewide population prevalence rates.

Race or Ethnicity	Special Education %	Statewide Population %
African American	20.7	9.0
Asian	7.8	7.2
Hispanic	20.6	12.4
Multi-Racial	17.3	2.6
Native American	21.8	0.5
Native Hawaiian	14.5	0.1
White-Non-Hispanic	16.5	80.6

**Note:** Racial and ethnic identity labels used are drawn from the U.S. Census language (Fermanich, 2020; U.S. Census Bureau, 2022).

Problems with the use of non-mainstreamed classrooms by disability and race are also noted as concerns. For example, in one U.S. state, Massachusetts Advocates for Children (2022) document that “over half of Black students with autism in Massachusetts are in substantially separate classrooms – double the rate for White students with autism. More than 40% of Latinx students with autism are substantially separated from their non-disabled peers” (para. 2). In the post-George Floyd era, social workers may also be more aware of the connection between racism and ableism due to the fact that 50% of people killed during encounters with police are people of colour with disabilities (Perry & Carter-Long, 2016). In their report for The Ruderman Family Foundation, the authors noted:

When disability is left out of the conversation or only considered as an individual medical problem, social workers may miss the ways in which disability intersects with other factors that often lead to police violence. Conversely, when disability is at the

intersection of parallel social issues, social workers come to understand the issues better, and new solutions emerge. (p. 1)

Additionally, the intersection of racism and ableism is also seen in the context of the COVID-19 pandemic, which has disproportionately impacted communities of colour (Centers for Disease Control, 2020b). Initial research suggests that about one-third of people who had the virus will develop what is called “long COVID,” which is now classified as a disability (U.S. Department of Health and Human Services, 2021). This new diagnosis is under the jurisdiction of the *Americans with Disabilities Act of 1990* (ADA), *Section 504 of the Rehabilitation Act of 1973*, and the *Patient Protection and Affordable Care Act* (Section 1557) if it substantially limits one or more major life activities. According to disability justice activist Rebecca Cokely, the inclusion of long COVID as a disability means that the United States will be adding an estimated 10 million people to the disability community who will be covered by the *Americans with Disabilities Act of 1990* in 2024 (Kendi, 2021, 9:03). This law provides workplace and other protections for disabled people, although the implementation and enforcement of this law are far from perfect (Pulrang, 2020). These are just a few examples of how both ableism and racism are related to one another. These historical and contemporary lessons about the intersection of ableism and racism give us some important context for what is seen in clinical practice today. When structural racism is considered by social workers, it becomes clear the ways in which pathology is applied to Black and brown bodies. And at the same time, the ways in which societies that benefit from structural racism are simultaneously responsible for facilitating environments that promote the development or highlighting of disability. Ableism and racism exist in a symbiotic relationship, as one is the tool of the other. Being aware of the intersection of racism and ableism is part of how social workers can begin to disrupt this reality in their practice and their larger communities.

### **The Disability Justice Movement**

The disability justice movement is a response to the very white and single issue, disability-focused disability civil rights movement. It is an intersectional movement that takes the fight against ableism to a different level. In describing this movement, Berne and colleagues note:

A Disability Justice framework understands that all bodies are unique and essential, that all bodies have strengths and needs that must be met. We know that we are powerful not despite the complexities of our bodies, but because of them. We understand that all bodies are caught in these bindings of ability, race, gender, sexuality, class, nation state, and imperialism, and that we cannot separate them. (Berne et al., 2018, p. 4)

Related to ableism is sanism, the definition of which is presented here. It relates to people who live with mental health disorders and the ways in which society responds to them as needing supervision, viewing them as incompetent, and even violent, for example, when that may not at all be the case. “Sanism is as insidious as other ‘isms’ and is, in some ways, more troubling, since it is largely invisible and largely socially acceptable. ... Sanism is a form of bigotry that ‘respectable people can express in public’” (Perlin, 1992, pp. 374–375). As Slayter & Johnson (2023) discuss, “sanism also refers to how people living with mental health issues have been thought of as ‘incompetent’, not able to do things for themselves, constantly in need of supervision and assistance, unpredictable, violent and irrational” (p. 10).

### The Disability Community

Both ableism and sanism refer to the whole disability community, which exists under a wide, diverse umbrella. Defining the term disability is not a straightforward process, as disabilities can vary widely and from a medical perspective can be related to vision, hearing, motor skills, cognition, health, mental health—or a combination of any of these. There are lots of debates about how to define disability in and outside of the disability community, but our approach is taken from the United States' *Americans with Disabilities Act* of 1990 42 U.S.C. § 12101 et seq. (1990), which is a federal civil rights law. To be covered by the Americans with Disabilities Act, a person must be disabled, which here is defined as having “a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment” (*Americans with Disabilities Act*, 42 U.S.C. § 12101 et seq., 1990, Section 3). In the law, all the impairments that are covered are not explicitly named. Below is a review of the major categories from a medical perspective. Slayter & Johnson (2023) summarize the categories as follows:

People with visual disabilities include people who have blindness, low vision or colour-blindness. Hearing disabilities are experienced by people who have deafness or are hard-of-hearing. Those with motor disabilities may have motor challenges or issues with gross or fine motor controls. Cognitive disabilities are experienced across a spectrum from intellectual and developmental disabilities to learning disabilities and memory challenges. Challenges with mental health disorders exist along a spectrum from neurotic to psychotic symptoms. Health challenges may be acute, long-term/chronic or sporadic. (p. 11)

It is also important to remember that some disabilities can be temporary, while others are permanent (Zola, 1993). For some people, disabilities are experienced from birth, and for others, disabilities are acquired after birth. There are both hidden and visible disabilities, leading to different experiences in society with ableism. For example, visible disabilities include conditions such as those experienced by someone with Cerebral Palsy who uses a walker, by a d/Deaf person who uses Black Sign Language (distinct from American Sign Language), or by a person with Down Syndrome. On the other hand, an invisible disability could consist of a traumatic brain injury, an autoimmune disorder, or bipolar disorders, all of which need to be disclosed in order to be identified (Slayter & Johnson, 2023).

On the use of the term d/Deaf, according to Carol Padden and Tom Humphries, in *Deaf in America: Voices from a Culture* (1990):

We use the lowercase deaf when referring to the audiological condition of not hearing, and the uppercase Deaf when referring to a particular group of deaf people who share a language—American Sign Language (ASL)—and a culture. The members of this group have inherited their sign language, use it as a primary means of communication among themselves, and hold a set of beliefs about themselves and their connection to the larger society. We distinguish them from, for example, those who find themselves losing their hearing because of illness, trauma, or age; although these people share the condition of not hearing, they do not have access to the knowledge, beliefs, and practices that make up the culture of Deaf people. (p. 140)

Another consideration to engage in when thinking about how to define disability is the fact that it is helpful to distinguish between an impairment and a disability (Slayter & Johnson, 2023).

As People with Disabilities Australia (2016, p. 3) notes “impairment is a physiological condition that leads to disability while disability is a result of people living with impairments when there are physical, attitudinal, communication or social barriers in the environment.” In the United States, 27% of adults, or over one-fourth of the population, live with an impairment that causes a disability (Centers for Disease Control, 2020a). Racial and ethnic diversity within the disability community is also worthy of consideration. For example, one in four members of the Black and African American communities have a disability, while one in six members of the Hispanic/Latinx communities does as well. In the American Indian and Alaskan Native communities, it is three in ten, and among Asian and Pacific Islander communities, it is one in ten and one in six, respectively (Courtney-Long et al., 2017). These statistics tell us that race, ethnicity, and disability are not siloed social identities, but are related and indeed intertwined.

### **Disability Language for Social workers**

Language is particularly important in the engagement process and extra important in anti-racist and anti-ableist practice with the disability community. Debates about the right language to use in talking about disability are ongoing. For many years, “person-first” language has been deemed a respectful approach to describing people with impairments in clinical settings, and for some practitioners and communities, it still is. More recently, many (but not all) disability community members, activists, and advocates have rejected person-first language and have embraced disability-first or identity-first language with an unapologetic embrace of disability as a social (and cultural) identity. The idea here is that there is nothing wrong with the word “disabled” and that it should be normalized instead of stigmatized. There has even been a widespread hashtag movement for the past five years on this topic: #SayTheWord.<sup>1</sup>

In this article, the authors use both identity-first language (i.e., disabled person) due to the preference of the authors and person-first language (i.e., person with a disability) when citing sources that prefer that language. In practice, however, practitioners should always take the lead of the person or people they are working with when considering whether to use identity-first or person-first language, as different people have different preferences. It may be easiest to refer to “the disability community” or “the disability communities” when referring to large groups of people instead of choosing one or the other (Ladau, 2021). It is also important to think about the social construction of disability—or how social workers are socialized to understand disability personally (in our families and social spheres) as well as professionally (in our clinical programs and our organizations). This is where the medical and social models of disability come in.

### **Medical and Social Models of Disability**

In order to contextualize our discussion of ableism and sanism, it is important to touch on the primary models influencing how our culture has conceptualized disability—and another model that counters it. Historically, a medicalized approach has been drawn upon to think about disabled

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<sup>1</sup> Note that in the #SayTheWord hashtag, the first letter of each word is capitalized, using the “Camel Case” method, an accessibility practice involving capitalizing the first letter of each word in a hashtag. Most hashtag users do not do this, which makes things difficult for visually impaired internet users who work with screen readers. A screen reader will read out the word as one—imagine trying to understand a complex hashtag such as #nothingaboutuswithoutusdisabilityvoice without camel case. Capitalizing the first letter of each word helps screen readers to understand that there are multiple words present in the hashtag.

people (Shakespeare, 2013). In this approach, disabling conditions are considered inherent to the individual, or more specifically a body part within the individual, with a focus on the need for a cure or a “fix” (Slayter & Johnson, 2023). In the medical model way of viewing disability, the identification and treatment of disabilities are the focused. This model considers social workers to be the experts as opposed to those with lived experience of disability. Rooted in the “personal tragedy theory of disability” or the idea that having a disability is a terrible thing or tragedy, this model posits that no good can come from living life disabled (Oliver, 2013; Slayter & Johnson, 2023). Much of the systems in which social workers function, such as diagnostic systems and billing systems, are based on this model, necessitating social workers to need to know how to navigate with it. Slayter & Johnson, (2023) note:

While some disabilities are easy to identify through the use of functional assessments (i.e., visual impairment, physical limitations requiring the use of a wheelchair), some disabilities require identification through clinical assessment tools such as diagnostic tools for mental health disorders or intelligence testing for intellectual disability, formerly referred to as mental retardation. (p. 14)

Western society also relies on the medical model structure for the receipt of disability benefits such as Supplemental Security Insurance in the United States, for example. However, the disability community has countered the medical model with a different model, known as the social model of disability. This model was developed by disabled British scholar Michael Oliver (2013) and is opposed in vision to the medical model. The social model theorizes that both the social and physical landscapes of our world are disabling as opposed to the body parts or processes thought of as disabilities in the medical model Slayter & Johnson, (2023) Further, in this model, disability is an indicator of both an ableist society as well as an inaccessible one. Here, disability is a socially constructed concept (Shakespeare, 2013). Society is what develops barriers for disabled people as opposed to bodies and it “fosters a cycle of ableist oppression and able-bodied privilege” (Slayter & Johnson, 2023, p. 15).

It is important to realize that the social model acknowledges the challenges of having a disability “but it does challenge barriers (i.e., attitudes, physical barriers, communication challenges) that restrict access to people with all forms of human diversity, including disabilities” (Slayter & Johnson, 2023, p. 15). The social model of disability has received some critiques with respect to its capacity to be intersectional. As cited in Slayter and Johnson, (2023, p. 15), Shakespeare and Watson (2002) note that the model may not adequately capture lived experience; “recognize the diversity of perspective in adopting a disability identity; or sufficiently acknowledge the experience of impairment and/or disability among multiple, intersecting identities.” It is important to members of the disability community who identify as disabled from a cultural perspective that social workers understand this model. And even if clients do not identify this way, it can be helpful to view a given client’s case through a social model lens—using a split-screen of sorts to view a case simultaneously through medical and social model lenses.

### **Disability Identity and Connecting with Disability Culture**

Social workers may be familiar with the importance of developing a clear racial identity, as has been discussed in a classic work by Atkinson et al. (1983). The same is true for the disability community. Some disabled people identify as disabled from a socio-cultural or political perspective. Some disabled people are not even aware that this option exists, and social workers can potentially open their eyes to the world of disability as a resource for them. In other words, for

some people with disabilities (or disabled people), not developing a positive disability identity is a missed opportunity to connect to a supportive network. For others, it is a choice NOT to identify as disabled either due to stigma, internalized ableism, or other beliefs. For example, some in the d/Deaf community do not identify as disabled but see themselves as part of a distinct cultural group altogether. Developing a strong disability identity is helpful with long-term emotional and psychological well-being. Fostering a strong disability involves both connecting with the disability community and with disability culture:

Disability culture, the sum total of behaviours, beliefs, ways of living, and material artifacts that are unique to persons affected by disability. Particular definitions of culture take many different forms and are context-bound (dependent on the cultural and geographic context in which they are formed), but three common ways of thinking about disability culture are (1) historical, (2) social and political, and (3) personal and aesthetic. Historical definitions of disability culture focus on art, poetry, language, and social community developed by disabled people. Definitions of disability culture that blend the social and the political focus on a minority-group distinction with common values of social and economic justice, radical democracy, and self-empowerment. Notions of disability culture grounded in the personal and the aesthetic emphasize a way of living and positive identification with being disabled. (Peters, 2015, n.p.)

Disability identity is a unique aspect of identity that includes identifying one's sense of self as disabled, in addition to one's connection to disability culture overall (Mackelprang & Salsgiver, 2015). Developing a disability identity does not happen alone, rather it happens along with others through what is thought of as a mirroring and modeling process with other members of the disability community (Mueller et al, 2020). For social workers, acknowledging and being supportive of the development of a person's disability identity is a vital part of practice with the disability community (Slayter & Johnson, 2023). In thinking about what this looks like in terms of specific case practice, there are three specific suggestions. First, designing service plans, planning for support, and looking at disability culture community options can assist in developing disability identity in positive ways. Second, connecting with disability culture may offer individuals the opportunity to be part of a strong community that provides support and camaraderie to its members. Third, disability culture resources are an especially valuable resource for social workers to know about when working with people who are isolated and without resources.

### **Disability Culture Resources**

First, disability culture is not the same as connections to disability social service programs. Disability culture lives, especially, in various media resources. In the United States the *Disability Scoop* resource covers developmental disability news while The U.S. National Center on Disability & Journalism is a clearinghouse for coverage on the community. Both the *New York Times* and *Forbes* have regular columns on disability culture topics written by members of the disability community worldwide. Social media and other groups reflective of disability culture include Sins Invalid; Disability Visibility Project; Facebook: Crip Camp 2020 and Facebook: Disabled Social Workers. Organizations founded by and for disabled people in the U.S. and beyond include but are not limited to: Autistic Self Advocacy Network; American Assoc. of People with Disabilities; and Disability Rights Education & Defense Fund. In digging deeper into learning about the disability community, social workers can explore some of the major disability culture hashtags on Twitter or Instagram to learn about the dialogues and debates in the community. Common

disability hashtags used on Twitter include: #DisabilityTwitter; #DisabilityVisibility; #Spoonie; #SpoonieLife; #DisabilityAwareness; #IdentityFirst; #DisabledAndCute; #DisabilityLife; #ActuallyAutistic; #DisaBodyPosi; #DisabilityTooWhite and #DisabledAndBlack. The term “spoon” refers to the pop culture idea of “spoon theory” as a metaphor for how much mental and physical energy a person has to accomplish their daily activities (Slayter & Johnson, 2023). People in the disability communities may talk about how many “spoons” they have as a unit of measurement of energy—and sometimes refers to themselves as “spoonies.” In sharing this information with clients, social workers can foster their own, “disability cultural competence” and will be providing tools that may assist clients on their disability identity journey.

While disability is a socially constructed identity like race or ethnicity (and other social identities) not all people with disabilities/disabled people want to identify as disabled—or see doing so as an option. It is important to remember that some people also do not wish to see disability as a positive thing, nor do they wish to identify with disability as a cultural group—and of course, social workers must “start where the client is.” As Slayter & Johnson, (2023) note, even people who view disability through a social model viewpoint can focus on the ways that social forces and structures are disabling. Social workers may play a part in connecting people to the potential for a disability identity. They may be able to open the door for people to become integrated into a different personal, social, cultural, and political identity through the social model of disability lens. Mueller et al. (2020) sum up the variation a social worker might see with respect to disability identity in their clients:

Disability identity, because it is about an individual’s own experience of their disability, is experienced in some way by everyone who has a disability. How this identity is expressed might look different based on each individual’s ideas, communication styles, and relationship to their own impairments. For example, they might participate in community by visibly seeming excited or comfortable when they go to certain disability community events. Most importantly, it is important that all people with disabilities are seen as part of a broader, powerful, and rich disability community. (n.p.)

As Slayter & Johnson, (2023) propose “one question to ask is does society make the claim for us or do we have a choice of social identity? Another question is how can helping clients embrace their disability identity assist them in achieving their case goals?” (p. 16). Regardless of where clients stand with respect to their disability identity, developing disability cultural competence will be good for case practice with any member of the disability community.

### **Disability Cultural Competence as a Tool in Anti-racist Practice**

To engage in anti-racist and anti-ableist clinical practice, social workers need to develop what may be termed as “disability cultural competence.” This is central to intersectional anti-racist practice with the disability community. The present authors frame this work using the term “disability cultural competence” as many in the disability community see disability as a culture. Social workers must continuously seek information about disability culture, without the expectation that this is a finite or time-limited process. There are ideally three levels that any organization should engage in, in order to implement or put in place the practice of disability cultural competence work. At the organizational leadership level, people need to make a commitment to disability competence as a priority, including facilitating all kinds of disability access (not just ramps). Leaders need to model commitment to this work, and managers must

commit to creating time and space to this work. This consequently allows individual social workers to engage in the reflective practice necessary to build their disability lenses.

Social workers need to develop knowledge about disability culture and disability history (Disability History Museum, 2020–2021). First, there is a need for social workers to examine attitudes about disability and engage in reflective practice around that. Social workers can consider their implicit bias about the disability community through Harvard University’s Project Implicit test about ableism (Project Implicit, 2011), for example. Additionally, reviewing the suggestions of Vilissa Thompson (a famous Black, disabled social worker) on checking your own ableism is another option (Brodsky, 2020).

Second, developing disability cultural competence over time also includes a careful look at the terminology social workers are using. For example, this may mean reconsidering our insistence on person-first language and respecting disabled people’s choice of identity-first language in many cases. Or it may mean considering how much of our language use ableist terms in many cases. It might also mean considering the extent to which we use ableist words or phrases in our language—given that language is linked to power, and those with power can control societal discourse (Ravishankar, 2020). Third, social workers also need to think respectfully about what they can call disability etiquette and how ideas about that etiquette play out in different parts of the disability community. Generally, disabled people ask that social workers presume competence, including, for example, the need for respect for bodily autonomy, speaking to the person rather than their companion/interpreter, asking before you help, and being sensitive to physical contact/equipment contact. The aforementioned also requires that social workers are sure to listen to the disabled person they are working with, without assuming they know better, and if they are in doubt about what to do, being sure to ask. Writer Andrew Pulrang (2020) sums up his disability etiquette request as follows:

- Don’t be afraid to notice, mention, or ask about a person’s disability when it’s relevant—but don’t go out of your way!
- Offer to help, but make sure to listen to their response, respect their answer, & follow their directions.
- Don’t tell a disabled person how they should think about or talk about their disability.
- Don’t give unsolicited medical, emotional, or practical advice.
- Don’t make a disabled person responsible for managing your feelings about their disability, or for your education on disability issues.
- If you make a mistake, just say you’re sorry and move on. Don’t try to argue that you were right all along.

Taken together, these steps, learning disability culture, examining our attitudes about disability, reviewing our disability terminology, and considering our approach to disability etiquette, go a long way towards the development of disability cultural competence. These actions must be paired with the fight for disability access and disability inclusion. Issues of access were not solved by the passage in the United States of the *Americans with Disabilities Act of 1990*, as the implementation of that law is fraught and embattled. Reading and acting on one of these guides to accessibility will go a long way to engaging the disability community and making them feel welcome (Balva & Tapia-Fuselier, 2021; Czuchry, 2020; Disability Intersectionality Summit,

2021; Mayor’s Office for People with Disabilities, 2020; Pulrang, 2021; Sins Invalid, 2017; Web Accessibility Initiative, 2021). Above all, remember the disability civil rights movement’s rallying cry, “nothing about us, without us” which is morphing more recently into “about us, by us!”

**An Intersectional, Anti-oppressive, Critically-culturally Competent Practice Model**

The authors now explore a theoretical practice model for intersectional, anti-oppressive, “critically-culturally competent” practice with the disability community developed by Johnson, Singh, and Slayter (2023) (see Figure 1).

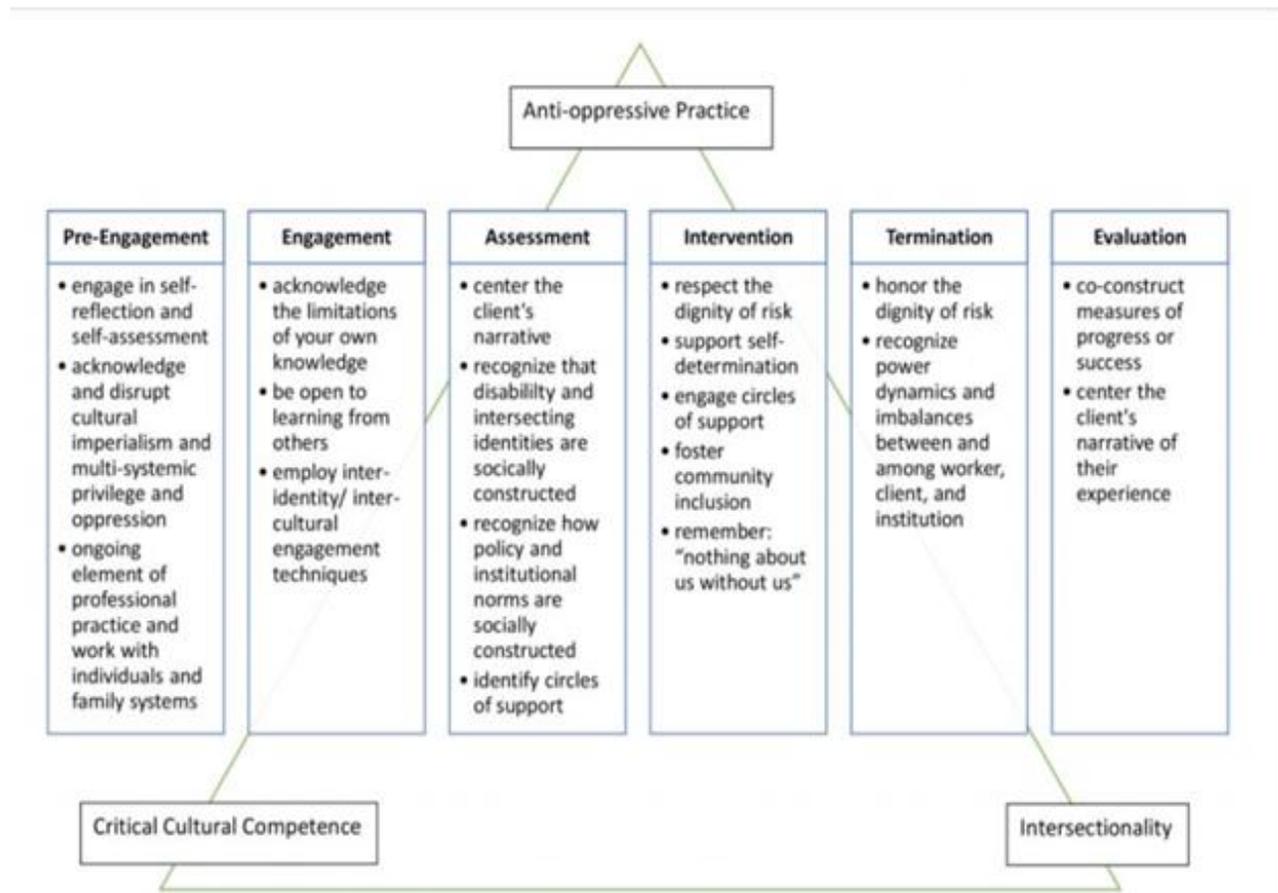


Figure 1. Model for clinical practice with the disability community (Johnson, Singh, & Slayter, 2023).

Building on the planned change model of social work practice, which consists of several phases such as engagement, assessment, intervention, and termination, Johnson, Singh, & Slayter’s (2023) theoretical practice model starts with a phase of “pre-engagement” added to the traditional model by the authors. The idea of pre-engagement work in which social workers reflect on their own “social location” and “social identities” in relation to their client before beginning case practice is what is designed here. In other words, as social worker Shimon Cohen has advised, it is about asking yourself “what have you done to prepare to engage in practice in

terms of your own knowledge of how race/racism and disability/ableism operates and your own critical analysis on their power and positionality in those realms?” (Cohen, S., personal communication, 2021). Pre-engagement is a step not explicitly found in other iterations of the planned change process, which typically begins with engagement. The authors of that model added pre-engagement as a key initial step to highlight the importance of engaging in reflective and reflexive practice regarding one’s “positionality,” assessment of cultural competence, and preparedness to engage in anti-oppressive practice (Johnson et al., 2023). The tenets of anti-oppressive practice call for social workers to be reflective about who they are as social workers, and what and how they engage in practice (Johnson et al., 2023). The key to that work is taking into account one’s social identities and how they may lead to privileged or oppressed positions in relation to one’s client (Johnson et al., 2023).

The model goes on into the engagement stage, the assessment stage, the intervention stage, the termination stage, and the evaluation stage. Guiding principles for empowerment-oriented best practices with the disability community reviewed above are infused here, all of which support being both anti-racist and anti-ableist. The authors have infused the stages of the model with the core principles of empowerment-oriented clinical practice with the disability community. First, community inclusion posits that all people have the right to be respected and appreciated as valuable members of their communities. This includes a focus on helping people to participate in activities in community settings as opposed to institutional settings, and generally being part of the larger community.

Second, self-determination is conceptualized as the process of making something happen in one’s own life. It is the opportunity to make choices, set goals, solve problems, and make a range of decisions for oneself. Third, the dignity of risk is the idea that everyone can learn from everyday risks (Slayter & Johnson, 2023). Central to honouring the dignity of risk is respecting an individual’s autonomy and self-determination to make choices. In order to respect a person’s dignity of risk, one should provide intermittent support even if others do not approve of the unsafe choice. As there is inherent dignity in the experience of everyday risk, this concept suggests that limiting a disabled person’s ability to make a risky choice or limiting their access to the community does not foster overall wellness in the long run. Fourth, circles of support are groups of people that can be formal staff, family members, friends, or neighbours who come together around a person to support them. Fifth “nothing about us without us” is a phrase that became the rallying cry of the disability civil rights movement adopted in the 1960s. This phrase communicates the idea that no policy should be decided by any representative without the full and direct participation of those whom the policy affected. Sixth, interdependence—disability justice activists honour the fact that it is interdependence that makes the world go round, not the independence that is too often reified in our culture and especially in our social service system.

In this theoretical practice model, on the points of the triangle in the figure, there are three frameworks: intersectionality, “critical cultural competence,” and anti-oppressive practice. These frameworks, reviewed below, are overlaid on the planned change model and can be connected to concepts undergirding Crip<sup>2</sup> Theory (Goulden & Katz Kattari, 2023). This theory challenges the

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<sup>2</sup> In the disability communities, “crip” is considered to be an inclusive term that can represent all disabilities, which are broad in their diversity. “Crip” is not only used to describe a disabled person (a within community word use only) but it can also be a verb: i.e., “cripping”, focused on revealing able-bodied assumptions as well as exclusion. Crip theory considers impairment as more than an “unwelcome presence.”

separation of what is defined by society as both “normal” and/or “abnormal.” It addresses the notion of “compulsory able-bodiedness,” and the expectation that normalcy is what everyone wants in their life (Goulden & Katz Kattari, 2023). Crip theory modifies a medical model-oriented dialogue about which bodies are undesired towards thinking about the “crip body” as desirable (Goulden & Katz Kattari, 2023). Using “crip” as a verb—to “crip” social work practice—is to illuminate compulsory able-bodiedness. This model is also strongly informed by disability critical race theory, known colloquially as “DisCrit,” which relates to the erasure of disability and how it is connected to race (Annamma et al., 2013; Erevelles & Minear, 2010). As an example, in elementary level special education in the United States, despite the fact that researchers within critical race theory have “many overlapping interests and concerns with DisCrit scholars, there are a dearth of theories and studies examining the relationship between race, ethnicity and disability” (Annamma et al., 2013). Additionally, the White-ness observed in disability studies has been challenged (Bell, 2017). DisCrit scholars elucidate how Black and brown bodies are “viewed as less developed than White bodies” and considered to be more “primitive”; sometimes even considered “sub-species of human” (Annamma et al., 2013, p. 2). Further, they say:

We believe that students of colour who have been labeled with dis/abilities live in this same complex world where they do not fit neatly into any one category. ... We believe that issues of perceived dis/ability constitute issues of equity that involve all people. ... We believe, for instance, that racism and ableism are normalizing processes that are interconnected and collusive. (p. 6)

In the spirit of these theories, Johnson, Singh, and Slayter (2023) overlap anti-oppressive practice, intersectionality, and “critical cultural competence” in the present practice model, the three of which we summarize below.

Anti-oppressive practice is a framework that centers on recognizing and challenging power and oppression, seeking equity, inclusion, and social justice for oppressed persons, groups, and communities, while emphasizing broader political, systemic, and structural understandings and explanations of social work and society. Intersectionality is an “analytic tool” and a “way of understanding and analyzing the complexity in the world, in people, and in human experience” (Collins & Bilge, 2016, p. 11). Intersectionality, as Collins and Bilge (2016) note, considers “social inequality, power, relationality, social context, complexity, and social justice” (p. 53). It is vital to consider all the social identities someone might have. “Critical cultural competence” is not the same as “cultural competence”; it is a more critical approach to cultural competence that has emerged with the argument that “awareness, knowledge, and skills alone are inadequate for culturally empowering clinical research [and practice]; they should be harnessed for social change” (Danso, 2015, p. 574). Critical cultural competence refers to “social workers’ ability to engage in high-level, action-oriented, and change-inducing analyses of culture and diversity-related phenomena” (p. 574). This concept also recognizes issues such as intersectionality, power differentials in the worker-client relationship, and examination of one’s social location or social position held in society based on social characteristics (Lusk et al., 2017). Social workers practicing without the use of a critical cultural competence lens may affect ineffective or low-quality services (Casado et al., 2012) and may deepen marginalization in traditionally oppressed communities, such as the disability community (Danso, 2015).

Taken together, these three frameworks give us a tool for doing anti-racist and anti-ableist work with the disability community, especially when merged with the planned change model.

Reflectivity is about unearthing the actual truth embedded in what professionals do, versus just what they say they do (Schön, 1983, 1987). Reflexivity, on the other hand, is the ability to look inwards and outwards to recognize how society and culture impact practice as well as how social workers themselves influence practice. In order to engage in reflectivity and reflexivity, social workers will want to pose questions such as “How do I create and influence the knowledge about my practice that I use to make decisions or plans for casework?” Reflexivity and reflectivity tie well to the concept of critical cultural competence. Pre-engagement work as a reflective and reflexive practitioner can also be accomplished through taking implicit bias tests, engaging in intergroup dialogue about race and disability, or participating in reading groups on these topics.

### **Developing an Awareness of Racism and Ableism in your Clinical Practice**

The following is a summary of how to engage in intersectional, anti-racist practice with the disability community. First, see disability as culture where appropriate, and consider how race intersects therein. Second, move beyond the personal tragedy theory of disability within a racial context. Third, respect disabled people as the experts of their own lives. Fourth, look for intersections of race and disability in your case practice. Fifth, keep developing your disability cultural competence lens intersectionally. Sixth, embrace the empowerment-oriented tenets of disability clinical practice. Seventh, use the intersectional, anti-oppressive practice model presented here. Eighth, engage in reflective, reflexive practice at pre-engagement, especially. Other actions that you can partake in to engage in reflective and reflexive practice today are listed below.

### **Explore Able-Bodied Privilege**

Autistic disability justice activist and lawyer Lydia X. Z. Brown (2016) has developed a list of over one hundred prompts about able-bodied privilege. Social workers can consider which items are most salient to them as a way to broaden their perspective. This consideration of the list can take place from a personal and/or a professional perspective, focusing on how they may or may not experience these issues themselves or how they may have encountered these issues as a social worker. While doing this work, one can consider how their race and ethnicity factor into the experience of able-bodied privilege. The following privilege statements are excerpted verbatim from Brown’s list to give the reader an idea of what this experience may be like:

- Strangers talk directly to me, and not to whoever happens to be with me because they assume that I am capable of understanding and responding.
- Random total strangers will generally not ask me very personal, invasive medical questions, especially if I am not transgender. If they do, they are considered extremely rude, and their questions are considered inappropriate and embarrassing (for them).
- When someone says that all they want is a “healthy” baby, I know they mean a baby whose brain and body will be like mine.
- The ways that I communicate, move, express my emotions, react to stress, and just get through my day, in general, are considered normal.
- I will never be trapped and prevented from going to a mandatory appointment by a set of stairs (or even a single step), a malfunctioning lift, or an out-of-service elevator.

- My type of body or brain is not used as a metaphor for brokenness, awfulness, mediocrity, or ignorance.
- Strangers do not attribute special spiritual giftedness to me solely because I am sighted, hearing, neurotypical, or walking.
- Using a computer or phone, reading, or even just being in public does not suddenly make me a spectacle for total strangers to stare at.
- If I have the money for it, I can decide spontaneously or suddenly to go to a movie, a lecture, a conference, a concert, a worship service, a happy hour, an amusement park, a restaurant, or just about anywhere else I please.
- I can assume that public safety information, like traffic signs, curb cuts, maps, detour notices, or other announcements will be accessible to me.
- Strangers won't pressure me into pursuing a specific career where I can make use of typically sighted, hearing, walking, or neurotypical strengths.
- No one asks me to speak as a representative of all people who are neurotypical or able-bodied.
- I don't have to rely on strangers to help me bathe or use the toilet, so I don't have to worry about whether I can trust them or not.
- If I succeed at something, I'm not considered an exception for people with brains or bodies like mine.
- Random strangers don't stop me to ask what's wrong with me.
- When I grew up, I learned about role models and celebrities whose bodies and brains were like mine without their body or brain being treated as a special inspiration.
- If I do choose a career that makes use of sighted, hearing, walking, or neurotypical strengths, people will not assume that I chose my career because I am sighted, hearing, walking, or neurotypical.
- I will not be left to die in the hospital from completely treatable and curable conditions like pneumonia because of negative assumptions about my quality of life or a belief that I would be better off dead.
- Other people automatically respect, validate, and understand my form of communication instead of denying or dismissing it as not real or legitimate.

### **Build Personal Disability Awareness with an Intersecting Racial Justice Lens**

Social workers can consider the values and/or ideas they hold that may unconsciously perpetuate ableism. Examining where these values originated is also of use to clinical practice. Finally, social workers can notice how becoming aware of disability culture, for example, may play out with disabled clients of colour differently from white disabled clients.

### **Recognize and Wrestle with Ableism with a Racial Justice Lens**

Just as it is important to acknowledge the potential for racism as social workers raised in a racist society, so, too, is it important to acknowledge the ways one may have engaged in the use of ableist language or the expression of ableist attitudes. Social workers can consider how they or their agency/organization/company unconsciously or consciously use ableist language or express ableist attitudes. Adding to this consideration should be thoughts about how race and ethnicity factor.

### **Adopt an Intersectional Lens in Practice**

Social workers can consider how they can look at the causes or movements they are already involved in through a disability framework that is also attentive to race and ethnicity. Social workers can work to lift the disability perspective and promote disability empowerment while being anti-racist.

### **Conclusion**

In conclusion, the authors draw on the wisdom of scholar Dr. bell hooks, who pointed out the importance of reflecting on how our race or ethnicity plays out in the sphere of our work—in this case, clinical practice (hooks, 1994). This observation could equally be applied to the ways that our able-bodiedness or disability plays out in work with clients, as well as the intersections of our race, ethnicity, and disability statuses vis-a-vis interactions with our clients. Reflective and reflexive practices enable social workers to temper the de facto power that they hold in the hierarchical relationship that they have with clients. In turn, this approach to practice allows clients to feel valued and experience some sense of empowerment and self-determination.

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**Author Note**

Correspondence concerning this article should be addressed to Prof. Elspeth Slayter, Salem State University School of Social Work, 352 Lafayette Street, Salem, Massachusetts, United States. Email: eslayter@salemstate.edu