

UNDERSTANDING EI FROM A SOCIAL MODEL

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PRIMARY GOALS

- Participants will distinguish the basic components of a social model of deafness/disability
- Participants will identify their beliefs and recognize the impact on families
- Participants will examine barriers in EI and discover ways to improve practice



MEDICAL MODEL VS. SOCIAL MODEL

Medical Model

Rao (2006) explains three assumptions of the medical model: the individual has an organic deficit, the deficit is objective and can be quantified, and exists regardless of cultural norms.

Social Model


The cultural or social perspective of deafness encourages a shift from “an overarching framework of normalcy to one of diversity” (Bauman & Murray, 2014, p. xv).

Why a social model?

Holler et al. (2021) found that the medical model has “unintended negative consequences” including focusing on a perceived deficit (p. 1). They found that practitioners who were familiar with a social model of disability preferred it to the medical model and would focus on ability.

Disability is “not determined by one’s physical capabilities but rather reflect the social consequences of that disability. In short, the individual’s perception of a handicap is tempered by the society in which the person lives” (Groce, 1985, p. 127).





A CONDITION THAT AN INDIVIDUAL HAS DOES NOT AUTOMATICALLY EQUATE TO DISABILITY. "RATHER, A DISABILITY IS FORMED ON THE BASIS OF A COMPLEX INTERPLAY OF A VARIETY OF FACTORS INTERNAL AND EXTERNAL TO THE PERSON. THESE FACTORS *MEDIATE* THE EXTENT TO WHICH A CONDITION RESULTS IN A DISABILITY".

DR. J. SCHERBA DE VALENZUELA,
PERSONAL COMMUNICATION, JANUARY 23, 2020

IS IT A DISABILITY?



EXAMPLES OF BARRIERS

SCREENING	DIAGNOSTIC PROCESS	EARLY INTERVENTION	SOCIETAL BARRIERS	ME
Imperfect equipment, location, etc.	Loss to follow-up, fluid, other medical complications, etc.	(Un)Qualified providers, loss to follow-up, location, timelines, choices, training, biases, etc.	"Normalcy," values, media, biases, family, fears, stigma, etc.	My experiences, fears, biases, knowledge, etc.

Q1 ————— How are my words creating barriers for DHH children and their families?

Q2 ————— How are my actions creating barriers for DHH children and their families?

Q3 ————— How does my practice create barriers for DHH children and their families?

Q4 ————— What can I do to reduce these barriers today?

NEXT STEPS FOR ME



thank you



THANK YOU!!

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References

- Bauman, H-D. L., & Murray, J. J. (Eds.). (2014). *Deaf gain: raising the stakes for human diversity*. Minneapolis, MN: University of Minnesota Press.
- Groce, N. E. (1985). *Everyone here spoke sign language: Hereditary deafness on Martha's Vineyard*. Harvard University Press.
- Holler, R., Chemla, I., & Maeir, A. (2021). Disability orientation of occupational therapy practitioners in physical rehabilitation settings: Tension between medical and social models in theory and practice. *American Journal of Occupational Therapy*, 75, 7504180010. <https://doi.org/10.5014/ajot.2021.042986>
- Petersen, B. T. (2022). *How hearing parents with deaf or hard of hearing children construct deafness through their early intervention experience* [doctoral dissertation, University of New Mexico]. University of New Mexico Digital Repository. [https://digitalrepository.Unm.Edu/educ llss etds/138](https://digitalrepository.Unm.Edu/educ_llss_etds/138)
- Rao, S. (2006). Parameters of normality and cultural constructions on 'mental retardation'" perspectives of Bengali families. *Disability and Society*, 21(2), 159-178.