



MHPSS and Disability Inclusion

A Creative Introduction into Concepts and their Practical Implications

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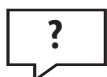
Brief information about the project

The Regional Project (RP) 'Mental Health and Psychosocial Support (MHPSS) in the Middle East' enhances know-how and exchange on the topic of MHPSS for refugees and host communities in the context of the Syria and Iraq crises. It complements bilateral projects and other development cooperation measures in Iraq, Lebanon, Jordan, Turkey, and Syria. Demand for MHPSS in the region is increasing because, in addition to the burdens caused by disasters, conflicts and displacement, economic prospects continue to decrease. Many people, especially refugees, experience their situation as hopeless. Social support is absent or diminishing. MHPSS measures aim to strengthen the psychosocial well-being of people, including in crises, to reduce the risk of long-term mental health complications.



Who is this paper for?

This paper hopes to inform actors in the humanitarian and development fields that offer MHPSS services, or that aim to do their work in an MHPSS-sensitive way, especially organisations that might offer their services to people with disabilities but do not specialise in disability support. The paper is not exhaustive in any way, and we encourage people who are interested in learning more about how to support people living with a disability to check the guidelines and links found at the end of this paper.



Why write about concepts in MHPSS and Disability?

The occurrence of war in the region coupled with socio-political and economic instability inevitably heightens the prevalence of physical impairments and exacerbates the general mental burden of individuals all of which could lead to disabilities.

MHPSS measures aim to strengthen the psychosocial well-being of people and counteract the development of long-lasting psychological difficulties and disabilities. Despite not being specialists in the sphere of disabilities, we decided to tackle the topic from the conceptual angle to address some of its ill-defined conceptual boundaries when it comes to psychosocial disabilities and their relations to MHPSS needs with the hopes that this would lead to increased inclusion and decreased stigma.

Silos that exist – some organisations are 'disability organisations', others are 'MHPSS organisations' – do not make it easier to develop an integrated understanding, which is important and necessary to ensure inclusivity. When approaching disability, there is often an emphasis on exclusively physical impairments such as sensory impairments, loss of limbs, spinal cord injuries, etc., and less emphasis on the mental health experiences and difficulties accompanying these impairments, especially outside of academic and professional circles. Even without impairments, some mental health difficulties cause exclusion from society, an inability to participate in the workforce, and an inability to maintain relationships.

This is why we looked into the literature on conceptual approaches, conducted a series of interviews,¹ and summarised them hoping to more clearly identify the boundaries between people living with psychosocial disabilities and those with MHPSS needs, while at the same time clarifying some of the conceptual and implementational problems that arise when striving to include those with disabilities into humanitarian and development project activities. This latter point, inclusion, is what we hope to be contributing towards. In this regard, a brief recommendation section will conclude this work based on the different interviews we conducted and the literature addressing disabilities in the context of organisational initiatives.

¹We would like to sincerely thank all those that participated in our interviews. Without their insights, this paper would not have been possible.

What is an MHPSS-informed approach to disability and a disability-informed approach to MHPSS?

An MHPSS-informed approach to disability involves prioritising the mental well-being of individuals living with disabilities. This approach ensures that professionals in the field of MHPSS, as well as those from other domains, are well-informed about the psychosocial difficulties and challenges associated with working with people who have diverse needs and different lived experiences compared to those without disabilities. An MHPSS-informed approach implies adopting a social approach to disability, which will be discussed later in this paper, and considering the ecological environment since many of the challenges that people living with a disability experience come from their immediate cultural surroundings. To offer MHPSS-informed support, it is important to look into how community members address disability, define it, relate to it, talk about it, and live with it.

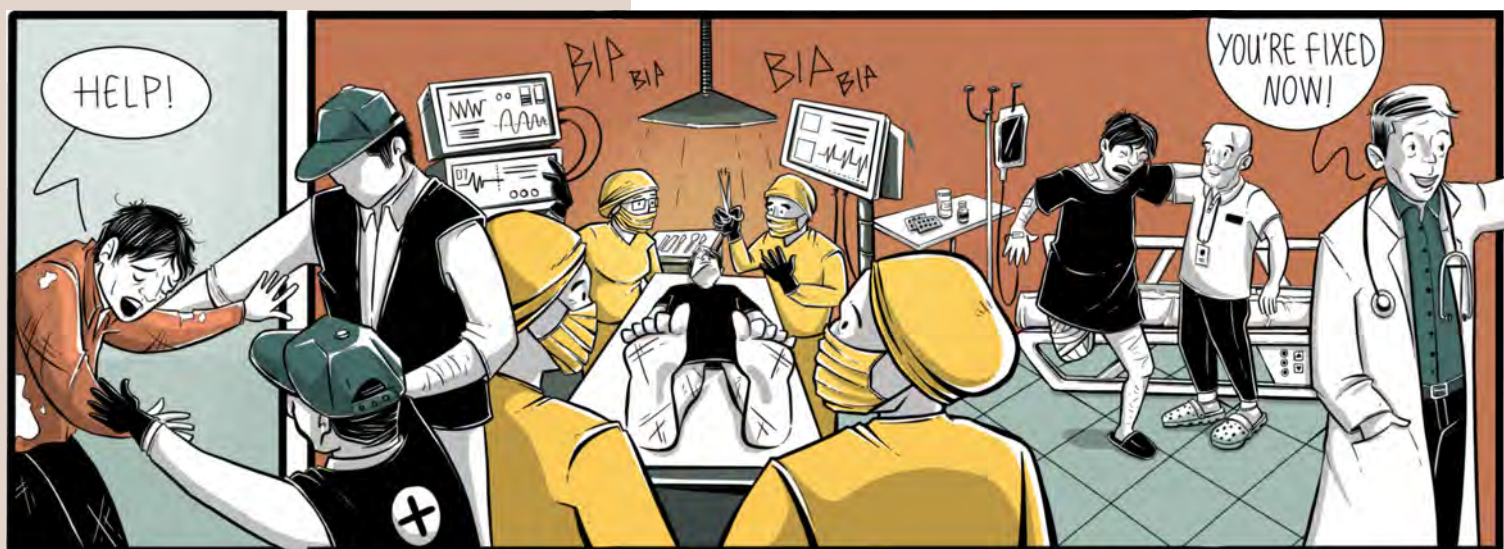
On the other hand, a disability-informed approach to MHPSS ensures that any MHPSS initiative considers persons with disabilities. There are many cases wherein certain material needs, like access to transportation, toilets, elevators, pathways, etc., are not considered during the planning of initiatives and implementation of projects. Even emotional needs such as stigma-free language, attention to trauma, inclusivity, and stressors of persons with disabilities are often not adequately considered in new projects. Persons with disabilities are often the most affected during pandemics, natural disasters, conflicts, and other emergencies. Their material and emotional needs must be considered.



Defining Disability

MHPSS is sensitive to how language shapes reality and conditions the behaviour of those labelled and their surroundings. The label ‘disability’ functions within a discourse wherein the common narrative that informs our understanding of disability inevitably affects the implementation of initiatives concerned with disability. Mindful of how a specific mode of interpretation can shape reality, an MHPSS-informed approach to disability carefully chooses which model to use when addressing the topic.

Rehabilitating the individual or reorganising society?



Medical Model

The medical model, for instance, views disability as a pathology that, like any other sickness, should be treated and cured to help a person become integrated into society. As such, disabilities in the medical model exist within the individual exclusively and cannot be understood outside of them. Society has little to do with this understanding of disability. This model focuses on prevention, cure, and care rather than integration and inclusion. Integration and inclusion are the ideal consequences once the 'sickness' is dealt with (Marks, 1997). The criterion for disability, like most other definitions and models, lies in the inability to perform certain tasks and properly integrate within society. The main difference to other models lies in the emphasis on pathology and 'abnormality' as the primary factors that define and inform disabilities. Working within this framework places greater emphasis on rehabilitating the individual rather than reorganising society.



Charity Model

The medical model led to the proliferation of certain discourses and initiatives which fall under the 'charity model' of disability. Building upon the medical model, the charity model views disabilities as pathologies and focuses on the consequences and possible initiatives to help care for these individuals. Because it relies on bio-medical definitions, this model posits persons with disabilities as victims of their own condition, and in need of specialised help and care to ease their integration within society, or even to separate them from society in specific institutions that address their needs. Special institutions, programs, and care are recommended, given their disability and limitations. Like the previous model, social re-organisation is not a topic of immediate concern. There is an emphasis on exclusion from the workforce, and the model does not look at the interaction between society and the individual. Thus, it does not capture the fact that a disability is often a disability only when viewed through the lens of society. This is why, from our point of view, the model most compatible with the MHPSS approach is the social model or at least an emphasis on the social model in tandem with other models.

Social Model

The social model considers that disabilities are a 'social construct', something that cannot be understood outside of the society in which an individual lives in, and may even be completely absent in certain cultures and traditions. The social model differentiates between impairments on the one hand (physical and/or psychological limitations) and disabilities on the other (social barriers). This distinction between impairments and disabilities is not exclusive to the social model. Still, the social model was one of the first approaches that completely contextualised disabilities and rendered them a social phenomenon instead of an individual one (Marks, 1997). A better understanding of the local and communal understandings of disability could lead to more focalised and context-specific psychosocial support initiatives, which is why the social model is considered a standard for most organisations working with persons with disabilities. Most definitions and models today are hybrids that incorporate the social model.

Mr. Fadi El-Halabi, psychotherapist, talk-show host, and the Executive Director of the Ecumenial Disability Advocates Network (EDAN) in Lebanon, helped define disability, inspired by the CBM (Christian Blind Mission) toolkit on disability, by putting it in the following way in an interview we conducted with him:

Impairments + Barriers = Disability

Impairments + Accessibility = Inclusion

“Impairments do not lead to disability if society is accessible.”



**Imagining an alternative world,
in which seeing is disabling**



How do models affect initiatives? Definitions in action

Historically, understanding disability as a pathology meant that segregation into asylums was common for those with disabilities and those with mental health problems. It was not until the late twentieth century that the rights of those with disabilities began being considered more seriously, and this was thanks to the agency of people with disabilities and their continuous calls for a better standard of living. A gradual shift began into more charitable approaches to disabilities focusing on welfare provisions and diminishing discrimination. The social model still had not become popular, so the language of pathology still operated, which limited the type of support organisations were willing to provide.

Disability was still not understood as emanating from society. For instance, the 1986 Disability Service Act in Australia defined disabilities as a condition that is “...attributable to an intellectual, psychiatric, sensory or physical impairment or a combination of such impairments; and results in a substantially reduced capacity of the person to obtain or retain unsupported paid employment; or to live independently”. Again, this definition implies that the problem is the disability, not the lack of inclusion and accessibility in mainstream society. This meant that most services focused on welfare provisions, specialised schooling, specialised institutionalisation, and other programs which were not necessarily ideal for integration, and this welfare discourse permeated Australia throughout the late twentieth and early twenty-first centuries (Cowden & McCullagh, 2022).

Similarly, the 1995 definition of disability passed through the United Kingdom’s parliament under the Disability Discrimination Act, “... a physical or mental impairment which has a substantial and long-term adverse effect on [a person’s] ability to carry out normal day-to-day activities”. Though the 1995 Disability

Discrimination Act was hailed as a step in the right direction and a victory for many people with disabilities, the lack of social considerations within the definition and conceptualisation meant that little social change could be observed institutionally for the next ten years, such as widening doorways, installing ramps, and having accessible translations and texts for those that have a visual impairment (Lawrie, 2020).

Comparing the aforementioned definitions to definitions that incorporate the social model, such as the 2006 definition of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), it becomes apparent that the focus is no longer on ‘cure’ and ‘rehabilitation’, but instead on ‘interaction’ with society. The UNCRPD definition states, “Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others”. Similarly, the International Classification of Functioning, Disability and Health (ICF) definition introduced at the 54th World Health Assembly in 2001 (with subsequent revisions over the years), which received approval from all 191 states involved, is an explicit attempt to merge the medical model with the social model. The definition states that disability is “an umbrella term covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations”.

With this definition, it becomes apparent how society at large has a much more significant role in causing disablement, and the barriers stem not only from an individual’s impairments but from social institutions and facilities that exclude them from mainstream society.

What are psychosocial disabilities?

Another aspect of disability inclusion we decided to explore and tackle is psychosocial disability, with the aim of raising awareness about the significance of examining various interpretations and definitions of this concept. Much like the broader definitions of disability and their implications on stigma and service delivery, the understanding of psychosocial disability varies among individuals and has diverse effects on their experiences and concerns. Psychosocial disabilities are more readily related to MHPSS since they could exist, and often do exist, in the absence of any physical impairments and have to do with the general well-being of individuals. Disabilities that develop due to mental health problems have been termed ‘psychosocial disabilities’ (NDIS). Not all mental health problems fall under psychosocial disabilities. In line with the definitions highlighted in the previous section, they are more readily termed psychosocial disabilities when they create barriers that do not allow the individual to integrate into society fully. The term ‘psychosocial disabilities’ is often used interchangeably with ‘psychiatric disability’, wherein a psychiatric disability is defined as a “mental impairment that substantially limits one or more of the major life activities of an individual; a record of impairment; or being regarded as having such an impairment” (Americans with Disabilities Act (ADA)). ‘Participation restrictions’, those restrictions which restrict individuals from participating in daily social tasks, determine when a condition is to be regarded as disabling. ‘Mental impairment’ is further elaborated by the Employment Opportunity Commission (EEOC) to include “any mental or psychological disorder, such as emotional or mental illness”. These mental impairments include most of the American Psychological Association’s Diagnostic Statistical Manual (DSM) definitions of mental illnesses, which are used internationally to diagnose. This, however, further broadens the scope of who can fall under psychosocial disabilities, which makes the line between psychiatric diagnoses and psychosocial disabilities ambiguous. Psychosocial disabilities also become harder to identify once we account for the unstable nature of mental health complications and the stigma associated with them, as the Disability Rights Fund Program Officer Paul Deany mentioned in the ninth session of the Conference of States Parties to the Convention on the Rights of Persons with Disabilities, “Psychosocial disability differs in that it can be episodic, invisible and often not well identified. Individuals or their families may hide it out of shame, denial or the fear of being locked up and stripped of their most basic rights” (Deany, 2016).



**3 different people, 3 different
psychosocial challenges**

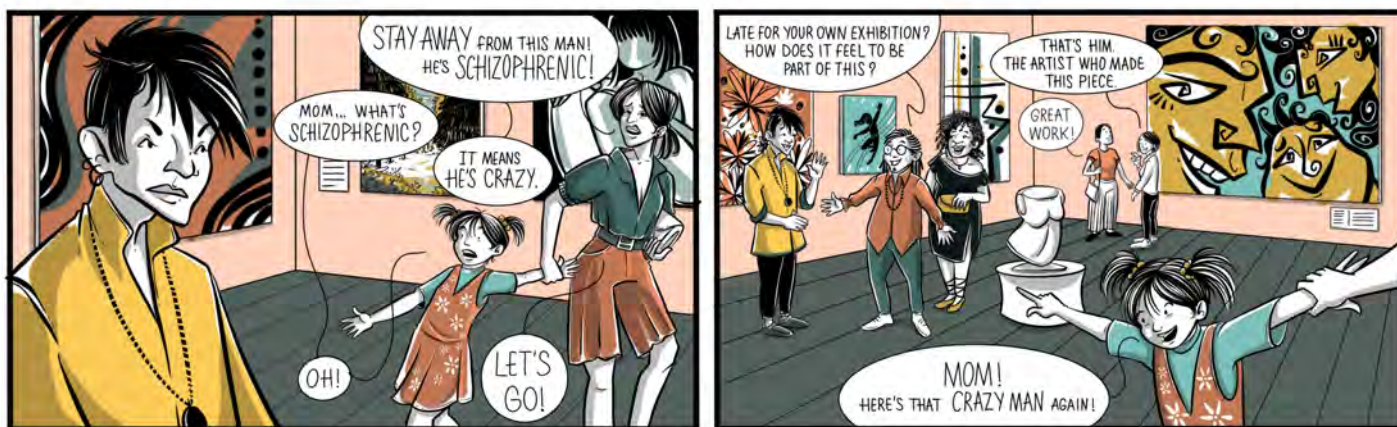
When are mental health conditions considered disabilities (and why is this not that easy to say)?

Not all mental health problems fall under psychosocial disabilities. The general rule of thumb throughout most of the literature and our interviews is that mental health complications become disabilities only when/if they limit participation in mainstream society. Lack of participation does not exclusively need to be a feature of the individual's mental health complications, it could also arise from society, and it often does. For example, because of a lack of resources and awareness, certain schools may not have the facilities and tools to accommodate someone on the autism spectrum. In this case, it is not just the autism spectrum disorder diagnosis causing the disabilities but the institution as well (the school). In other cases, however, things are less clear-cut. Consider someone with generalised anxiety disorder. They might have a steady job, be in a rewarding relationship, and have full access to most social institutions. However, periodic episodes may occur when the anxiety becomes acute or resurfaces. Is it accurate to label the person as disabled? Conversely, many displaced refugees with no previous history of psychiatric disorders may, due to large amounts of stressors, develop depressive or traumatic symptoms that interfere with their daily living and affect their ability to function. Is it accurate to label them as disabled, knowing the conditions that give rise to their disablement?

Some definitions and governmental institutions suggest a time criterion to deal with this grey zone. For instance, the UNCRPD definition mentioned earlier states that the impairment (physical, sensory, mental, or intellectual) must be 'long-term', though it is not mentioned how long is 'long-term'. The government of Jordan, for example, employs a very similar definition "A person who has long-term physical, sensory, intellectual, mental, psychological or neurological impairment, which, as a result of interaction with other physical and behavioural barriers, may hinder performance by such persons of one of the major life activities or hinder the independent exercise by such persons of any right or basic freedom" but defines 'long-term' as something which cannot be resolved within two years. In other interviews we conducted, some people said that a condition could only be considered a disability if it is permanent. However, it could be argued that an MHPSS-sensitive approach to disability inclusion should not employ strict time criteria since this might exclude many from conceptions of disability, even though they suffer from real but perhaps not permanent or long-term disabling conditions. Many people may have disabling conditions for only one year, for instance, or disabilities that come and go. We believe that those individuals should be able to benefit from psychosocial support that targets individuals with disabilities, and more importantly, psychosocial support initiatives should be mindful of disabilities and specifically psychosocial disabilities that are not always bound by extended time criteria.

What is so difficult about labelling, and why is it serious?

The label 'person with disabilities' or 'disabled' has many implications. For starters, in many communities, there is stigma around disability, wherein community members can associate disabilities with weakness or punishment. Persons may become detached from the community due to the label, think less of themselves, and/or face increased psychological distress due to it. Shame is also associated with disability, and many stories we heard during our interviews document how a child was neglected because their disability was thought to bring shame to the family. A plethora of studies document how people with disabilities, especially at a young age, are at an increased risk of maltreatment, abuse, and neglect, which poses problems to their well-being at a later age (Leeb et al., 2012; Gil et al., 2009; Govindshenoy & Spencer, 2006). Stigma could arise both from society and the individual themselves, and both these facets of stigma could have a detrimental impact on the person's well-being and those close to them. Societal stigma, often called perceived stigma, relates to the general society's misconceptions about certain disabilities, especially as it relates to psychosocial disabilities, with attitudes ranging from fear, blame, mistrust, and even pity towards the person with the disability. The individual can then internalise this perceived stigma, creating a loop wherein shame and hopelessness are projected inwards. Though stigma related to physical disabilities has different implications than the stigma that arises from psychosocial disabilities and mental health, both create an unhealthy pattern that can severely impact the individual's willingness to seek the required help and maintain self-worth and self-confidence. The mental illness label itself is highly stigmatised in the region. Given this, many individuals who need mental health support do not seek it and do not discuss their problems, which only further worsens their difficulties. As we will show later, this stigma is often verbalised with problematic and insensitive statements, such as calling a disabled person a 'cripple' or someone with mental health difficulties 'crazy'. Children are often told to stay away from certain people because they are 'possessed by demons', referring to someone with a possible case of schizophrenia, or are simply encouraged not to associate with an individual because of their mental health conditions.



Stigmatising hides the talents and achievements of people with psychosocial disabilities

Another important point is that employing 'disability' in a given community might be an intrusion. Some communities may not have the language for disabilities, they may not view certain conditions as disabilities, and they might relate to impairments differently from other societies. This was the case, for instance, for some indigenous populations in New Zealand, who did not have a word for 'disability' and found the word itself to be problematic. Unsatisfied with this label, they introduced the word 'whaikaha', which means strength, power, or 'enabled', in hopes of reclaiming their language and their relationship to their bodies.² Overall, introducing new labels in communities can create unwanted societal changes, and have an unwanted impact on conceptions and worldviews. Therefore, there should be no imposition of concepts and labels on people who do not feel the need for those in the first place such as with quick diagnoses.

An MHPSS-sensitive way to employ labelling is to allow community members and individuals to employ the label as they see fit. We are unsure how this would look in all cases, but it involves first understanding the person's language when speaking about disabilities. If there exists a similar equivalent to disability within the community, it should preferably be used. Also, especially regarding psychosocial disabilities, the label of 'disabled' or 'person with disabilities' should be avoided until the individual themselves feels confident in employing it or until sufficient awareness is raised and the stigma associated with the disability is addressed.

The important point remains that with or without the label, all MHPSS and other support initiatives that aim to be MHPSS-informed should accommodate persons with different types of disabilities, no matter the label. Again, this implies things like easy access, careful language, awareness raising, and contextual awareness. These considerations should be independent of the intricacies of labels.



The dangers of labelling

²See: "Who we are: Whaikaha - ministry of disabled people. Whaikaha. (n.d.). <https://www.waikaha.govt.nz/about-us/who-we-are/>" for more information.

Psychosocial dynamics around disabilities in the Middle East

Unfortunately, there is insufficient data from the Middle East regarding disability prevalence, and the Middle East is often grouped with North Africa (constituting the MENA region), for instance, in one of the most comprehensive studies carried out by UNICEF in 2022. However, the results did show that, including psychosocial disabilities, the MENA region has the second highest prevalence of disabilities among children (0-17 years old) at 13% (UNICEF, 2022). Their study examined Iraq, Tunisia, Palestine, and Algeria, and only children under 17 years old were considered for data collection. Interestingly, psychosocial disabilities predominated in all four countries, where 'signs of depression', 'lack of self-care', 'difficulty concentrating', or 'difficulty making friends' were some of the recurring problems. These different difficulties were related to 'psychosocial functioning' and thus considered disabilities.

Other studies focusing on psychosocial disabilities in the Middle East noted that across Palestine and Lebanon, the prevalence of mental health disorders among adults was also high, approximating 24% and 25%, respectively (based on a study carried out in 2006 in Palestine and another in 2008 in Lebanon). In Jordan, Syria, Iraq, Lebanon, and Palestine, witnessing war and conflict were some of the greatest risk factors for psychosocial disabilities (Bolton, 2016). Especially for the newer generations in Syria and Palestine, frequent stress, depressive symptoms, and grief were attributed to conflicts, shelling, displacement, and other consequences of war.

In Lebanon, the civil war and memories of torture still plague many individuals, and many claim that traumatic experiences lead to their failure to reintegrate into society. Similarly, in Iraq, suicidal ideation and mental health disorders are often traced back to the history of war and the many conflicts in the region.

Another recurring topic in our interviews and across the literature, especially regarding mental health in conflict settings, is the onset of disability. In other words the distinction between a disability acquired anew and one present since birth can indeed make a difference. In the former, highly prevalent in conflict settings, the onset of a new disability provides a set of challenges previously not present. The lack of MHPSS-informed support systems, awareness, and institutions often severely impacts the mental health of those involved.

Similarly, psychosocial well-being has been diminishing in many Middle Eastern countries due to increasingly difficult conditions. The period following the war in Syria, that included COVID-19, housing crises, and deteriorating economies saw an increase in demand for therapy, an increase in suicides, and an increase in unemployment, especially after COVID-19 and accompanying lockdowns, and aggravated by the worsening socio-economic conditions, especially in Lebanon, Iraq, Syria, and Palestine (UNICEF, 2022; Bolton, 2016).

In these countries, socio-economic and political deterioration continues to proliferate, and the outlook for political and economic stability does not look promising, causing further psychosocial difficulties related to feelings of helplessness and anxiety about the future. With such high stress levels, psychosocial disabilities could also be expected to have risen. Many people may feel disabled and unable to participate in daily social tasks. This feeling of hopelessness only gives rise to more risk factors.

Phantom limb, phantom house, and the psychosocial damages of war



What are the mental health and psychosocial well-being impacts of physical impairments?

People with disabilities face several challenges that impact their mental health and psychosocial well-being, including exclusion from mainstream society, discrimination, pain, loneliness, and increased financial burdens—all of which are risk factors for developing mental health problems.

Many people with disabilities also face increased financial difficulties, expensive and consistent need for certain medications, possible recurring surgeries, trouble maintaining a steady job, need for extra supplies and equipment, and other financial burdens that could cause significant amounts of stress economically and mentally. In the United States, a recent study of the Centers for Disease Control and Prevention suggested that almost one-third of those with disabilities (32.9%) experience mental health complications and are more likely to face these issues than people who do not have disabilities (CDC, 2020). Similar findings are likely to be found in the Middle East and elsewhere due to the immense stressors people with disabilities face.

In many circumstances, those with disabilities are among the most marginalised. During the COVID-19 lockdowns, for instance, persons with disabilities

were severely affected (Goggin & Ellis, 2020; Lund et al., 2020). Especially in low-income settings, with the absence of social security services, many of the health services were not prepared to accommodate persons with disabilities, while persons with disabilities also felt excluded from public service announcements, emergency protocols (with regards to transportation or other access), and felt that their disabilities were not being seriously considered when discussing lockdowns. This lack of accommodation goes beyond COVID-19 into virtually every other aspect of life, especially in emergencies.

This marginalisation compounds the feelings of worry and anxiety that many persons with disabilities face and could help explain the high prevalence of mental health complications among those with disabilities. This short section is not an exhaustive list of the mental-health stressors persons with disabilities face or the daily challenging obstacles many navigate. As an MHPSS project, we find it crucial to be aware of these many different challenges, namely in hopes of reducing them and problematising the lack of inclusivity towards those with disabilities in many circumstances.



What would inclusivity look like in the context of project implementations?

We use the word 'inclusivity' frequently in humanitarian and development work. We say that society must be inclusive, language must be inclusive, MHPSS must be inclusive. However, what does this actually look like? To better understand inclusion, it is perhaps important to understand its opposite, exclusion. Exclusion comes when we feel we do not belong, feel left out, and feel like we are not part of something. Concerning persons with disability, this feeling of exclusion exists when someone feels left out from general society. Someone in a wheelchair trying to access a public restroom or use public transportation will feel as if they do not belong if they cannot access the restroom or board the bus, as if society was built without considering their needs. This exists on many levels, across different types of impairments. Someone with visual impairments lacking the proper cues to navigate, someone with intellectual difficulties lacking the proper tools for education, someone with PTSD working in a trauma-inducing environment, and so on.

In order to claim to have an inclusive society, people should not feel excluded. Though a seemingly obvious statement, it needs to be taken more seriously. It is imperative that members of the disabled community do not feel excluded and this is where the 'disability-informed approach to MHPSS' comes into play. Humanitarian and development projects and initiatives should always be informed regarding the needs, tools, language, and preferences individuals with different impairments require. We have become accustomed to normalising only one type of body and organising the world accordingly. Instead, learning to appreciate and include different body types and minds in projects is imperative to ensuring access and inclusivity.

During project implementation, it must be ensured that things like accessible pathways, braille, accessible restrooms, and other necessary accommodations are present and available. Just as the COVID-19 pandemic most severely affects those with disabilities, in the absence of the proper accommodations, all emergency settings would most negatively impact those with disabilities.

On raising awareness and stigma

It is also imperative that the general population has adequate awareness of the dynamics surrounding disabilities. Many of the people we interviewed expressed the need to bring these discussions into school and university curricula, especially for psychologists and social workers. It makes little sense that people could graduate from years of study without once talking about disabilities. Preschools and elementary schools could already start raising awareness through the choices of books, video programs, and topics covered. Organisations can promote awareness by establishing environments where these conversations and topics are encouraged, as well as promoting diversity in their workforce, being more inclusive in the choice of images on publications (often, persons with disabilities are depicted on covers only if the content pertains to disabilities), and supporting comprehensive research and educational programmes dedicated to disability studies.

With increased awareness-raising, it is hoped that the stigma associated with disabilities will decrease. The linking of disability with weakness, punishment, and feelings of guilt is largely a result of inadequate understanding about disabilities and the correct approach to address them. However, one of the main issues regarding awareness is how to be sensitive to the well-being of individuals with a disability. MHPSS-sensitive approaches should inform our language, actions, and behaviours. That is to say, in many of our interactions, we may not be mindful of our insensitivities – e.g. through actions like helping when it was not asked for or improper eye contact. For this reason, we thought it apt to conclude with a ‘disability etiquette’, informed by our interviews and existing resources.³

³This disability etiquette was compiled by the authors of this report based on available resources, though many others like it exist. You could find a few of these other etiquettes here:

- Disability Etiquette - A Starting Guide - Disability:IN (disabilityin.org)
- Disability Etiquette for the Workplace (understood.org)
- Disability Etiquette: Better Respect People with Disabilities | BraunAbility
- 15 Disability Etiquette Basics (accessibility.com)

What would a 'Disability Etiquette' look like?



Address the disabled person directly

Often, there is a tendency to address the person accompanying a person with disabilities instead of the person with a disability themselves. When someone is blind, for instance, or has an intellectual disability, we tend not to address them directly for some reason. This is common in restaurants, as well as other social gatherings. Persons with disabilities, unless otherwise informed, are perfectly able to speak for themselves!



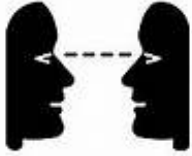
Only help out when asked

Out of common courtesy, we may rush to help someone out in a wheelchair by pushing them along the street or elsewhere without them having asked. Many times our help also involves physical touching. There is nothing wrong with helping, but sometimes the person was not looking for help, and our trespassing of their ability to act independently may not be welcome. It is always better to get the person's consent before helping.



Be mindful of your language

We have much to be mindful of regarding our language. For instance, there are obvious things like not using derogatory language or insensitive and outdated words like 'cripple' or 'retard'. However, there are also more subtle things, like being mindful of how we address a person with disabilities. Referring to people based entirely on their disability should be avoided. For instance, 'blind guy', 'disabled guy' or 'handicapped' should be avoided because they reduce the entirety of the individual to their disability when in reality, they are much more than that. We should also be mindful not to use 'pity language' and talk to persons with disabilities as if they are victims. Avoid using 'suffering from' or 'deficiency' or 'victim of'. Conversely, we often give too much praise, telling them how brave they are, how hard it must be, and other things that put them on a pedestal. It is (obviously) fine to be nice, but constantly putting a person on a high pedestal accentuates our differences. In most cases, the person with disabilities was not looking for our praise. Finally, we should be careful not to be intrusive or ask about traumatic experiences. Our question may be trauma-inducing, and the other person might not want to talk about their disability on every occasion.

**Be mindful of your eye-contact**

Staring at a person's impairment, or avoiding eye contact altogether, are (unfortunately) normal reactions. The solution is simple, however. Make the same amount of eye contact as you would with anyone else! Where we look and how long we look for may well make the other person insecure, so it is important to be mindful of our gazes.

**If not qualified, acknowledge you are not an expert**

Especially regarding psychosocial disabilities, many people tend to downplay the severity of the issue and offer advice on how they got out of a slump or remain happy. Unwanted advice about healthy lifestyles, coping strategies, and mindsets are often insensitive to the realities the other person is facing. Similarly, we may exhaust a person with physical disabilities about stories of our 'cousin' and how a miracle drug or an operation helped them end their disability. We may also offer advice on how they can feel better about themselves and better navigate their life. Again, it is fine to offer advice and be friendly. However, this requires considering the other person's boundaries, examining our relationship with them, and the context in which we tell them before offering advice. On the other hand, acknowledging that we are not experts, and seeking more information from professionals or the person with disabilities themselves, goes a long way in raising our awareness.

**Accessible****When available, ensure proper accommodations**

Of course, many of us do not have the resources to ensure some of the accommodations needed for certain disabilities. Nevertheless, suppose we invite our colleagues from work to a restaurant or hold an event. In that case, it is always encouraged to look for locations that are accessible to persons with disabilities. Ensuring a location has the proper accommodations could be as simple as making a quick phone call.



Do not make assumptions

The only assumption we should make about persons with disabilities is that they are like any other individual. They can live fulfilling lives with meaningful connections, jobs, education, etc. We should not assume otherwise or assume a person needs our help, advice, or pity.

Be mindful of your language and behaviour and be considerate.



Additional Readings

For those who are interested in learning more about disability inclusion, you can refer to the below resources:

- [CBM Disability Inclusive Development Toolkit \(cbmuk.org.uk\)](http://cbmuk.org.uk)
- [Disability Inclusion Toolkit \(fordfoundation.org\)](http://fordfoundation.org)
- [Disability Inclusion | CDC](http://disabilityinclusion.cdc.gov)
- [Accountability for the Rights of People with Psychosocial Disabilities - PMC \(nih.gov\)](http://nih.gov)

For any questions related to the paper, you can reach out to the GIZ MHPSS Regional Project on contact-MHPSS-rp@giz.de.

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