

# Year 10 PDHPE Assessment Task – Unit One: Making A Difference

- 5.1 analyses how they can support their own and others' sense of self
- 5.2 evaluates their capacity to reflect on and respond positively to challenges
- 5.3 analyses factors that contribute to positive, inclusive and satisfying relationships
- 5.7 analyses influences on health decision-making and develops strategies to promote health and safe behaviours

**Due Date: Thursday 15<sup>th</sup> March, 2018**

**Part One:** Complete the attached work sheets to the best of your ability.

**Part Two:** Though we will engage with all of these issues as a class, you are to choose one of the following areas to explore further in your own time:

## a) Seeing Disability Clearly

- a. Investigate the approach of Stella Young by watching her TED Talk "I'm not your inspiration, thank you very much."  
[https://www.ted.com/talks/stella\\_young\\_i\\_m\\_not\\_your\\_inspiration\\_thank\\_you\\_very\\_much](https://www.ted.com/talks/stella_young_i_m_not_your_inspiration_thank_you_very_much)
- b. Write your answers to the following questions on two A4 sheets of paper:
  - i. How would you describe Young's approach to life and to disability?
  - ii. Have you thought about her perspective on disability before or do you have to admit that you identify with the Year 11 student in her Legal Studies class? Explain.
  - iii. Describe what you think Young means when she talks about Social Disability?
  - iv. Look at the provided extract "Medical and Minority Models of Disability" from Natalie Swann's paper entitled *A Discussion Paper on Disability and Theology* Prepared by: Natalie Swann in consultation with the ANGLICARE Theological Committee, ANGLICARE Diocese of Sydney Social Policy & Research Unit, May 2010. How does reading about these two models provide you with new insight into disability and the way we respond to it as a society?

## b) Overcoming Adversity to Succeed

- a. Watch the Kurt Fearnley interview with Anh Do (in Student Public under Yr 10 PDHPE 2018)
- b. Take two A4 pages to answer the following questions:
  - i. What setbacks did Fearnley overcome to get to where he is today?
  - ii. Who advocated for Fearnley and made his success possible?
  - iii. Which times in his life does he describe that show how different he is from others? What things does he say that show he's just like everyone else?
  - iv. What three things do you think Fearnley would describe as his greatest life achievements and why?
  - v. If you were faced with his challenges, how do you think you would have coped?
  - vi. Which of the models of disability do you think Fearnley would subscribe to?
  - vii. How is he like Stella Young? How is he different?
  - viii. Are we "allowed" to view Kurt Fearnley as an "inspiration"? Why or why not?

## c) Sexual Harassment in the Workplace

- See article Is 'That' Sexual Harassment? How to Tell, Using 'Cooper's 6 Levels.'
- Read the article and devise a fair process for investigating claims of sexual harassment in the workplace. Write it up on one A4 page to submit with your worksheets.
- Choose one of the real life stories coming out of the #MeToo or #TimesUp movements. How did the behaviour of the perpetrator compare with the six levels described in the article?
- What do you think needs to change in the film and related industries to protect potential victims of sexual harassment in the workplace? (The last two answers should be attached on one A4 page to the back of this booklet.) See Oprah Winfrey's Golden Globes speech as a point of reference.

**To submit your finished task, submit the completed worksheets and attach your additional two A4 pages to the back with a stapler or put all the papers inside one plastic sleeve.**

## 2.6 Medical and Minority Models of Disability

There are two key models for understanding and explaining disability. The first, the medical model, defines disability as a loss of bodily function. Within this model, disability is perceived as entirely negative and treatment is directed at restoring function (McCloughry and Morris 2002). Disability, a deviation from what is acceptably 'normal', is identified in the body of the person with a disability. This way of thinking about disability as deviance from the norm can lead to ways of talking about people with a disability as less than whole, where something is missing. Medical practitioners often struggle to balance objectivity and scientific detachment with the empathy and pastoral care required by persons with long-term, persistent illness or disability (ibid). The professionalism required of medical staff can also have the negative consequence of shutting out the patient from participating in decision-making. A much broader theological question about the scope and limit of medical science comes to the fore here also. Given that the Bible reveals that disease and disability come as result of the Fall and sin, it is our expectation that appropriate medicine should be therapeutic, playing a role in 'correcting' the disease or disability, but how much and to what extent? Where do disability and dysfunction stop, and normality begin? In addition given the painfully obvious limits of even remarkably powerful medical intervention, the Christian person and community's response must be multifaceted, not simply medical and 'corrective' alone but offering care –physical, spiritual and social, showing 'neighbourliness' and hospitality. This relates directly to the second prevalent model of disability.

The second model is the social or minority model of disability. It shifts the focus of attention from the person with a disability as a patient (to whom things are done) to the person with a disability as a citizen (who does things). Whereas the medical model locates disability in the individual, the social model locates disability in the society that facilitates exclusion. The medical model strives to change the individual with a disability in ways that help them participate in society, while the social model calls for changes in society to allow the full participation of persons who have some form of physical or psychological impairment (ibid). The social model of disability is necessarily political, in that it calls for changes in values and attitudes rather than scientific advances.

These models each have helpful and unhelpful elements. While the medical model can unhelpfully identify disability as personal tragedy, the social model can go too far in disallowing grief and pain (ibid). Helpfully, the medical model reveals the embodiment of disability and the very personal experience that can be, while the social model identifies the ways in which disability is so often a result of prejudice and discrimination rather than just the physical or psychological effect of impairment on the individual.

Healing narratives in the gospels recount the way Jesus both restored people's bodies and addressed their exclusion from the community and from relationship with God. In Matthew 9, Jesus heals the paralytic as evidence that he can heal the much more important wound that is sin; he came not only to deal with the oppression of disability "but to address the deeper and darker oppression caused by evil itself...which is not just paralysis but death itself" (Wright p98). Jesus restores the paralytic not only to health but to relationship with God. In Luke 5:12-16, Jesus heals a leper whose express objective was to be made clean. Jesus grants his desire and makes him clean, which in this context involves healing his illness and restoring to him the ability to worship at the temple. The leper is free to rejoin the community and participate in worship. Restoration is not only appropriately manifest in the body of the follower with a disability; Jesus rebukes the Israelites for their lack of hospitality and generosity to people with a disability (e.g. Luke 10:25-37). We can see from these examples that Jesus is not concerned simply with either physical restoration or restoration of community, but that he heals the body as a means of restoring relationship (cf. Berinyuu 2004).

From *A Discussion Paper on Disability and Theology* Prepared by: Natalie Swann in consultation with the ANGLICARE Theological Committee, ANGLICARE Diocese of Sydney Social Policy & Research Unit, May 2010