

RESEARCH ARTICLES

Challenging Assumptions about Disability and Special Needs in Chapel Communities

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Children in the US are born with disabilities in ever increasing numbers.¹ Approximately 17% of children in the US possess a significant developmental disability.² The Department of Education also estimates that 15% of all students in public schools receive exceptional student services often related to a disability.³ Yet as we in the Chaplain Corps look at Army chapels, this population appears absent.⁴ While some blame the lack of disability ministries or accommodations, I suggest a simpler explanation; many families simply feel unwelcome.⁵ One study that suggests that half of families with disabled members refrain from participating in faith communities because they feel unwelcome supports this claim.⁶ The attitudes and assumptions of the community often drive this unwelcoming feeling.

I should note that my son has a disability and is currently on his third long-term inpatient hospitalization. My son and our family have been on the receiving end of many of the assumptions outlined below. And while we have

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¹ For instance, related to Autism, see Sayyed Ali Samadi, Cemal A. Biçak, Hana Noori, Barez Abdalla, Amir Abdullah, and Lizan Ahmed, "Autism Spectrum Disorder Diagnostic Criteria Changes and Impacts on the Diagnostic Scales-Utility of the 2nd and 3rd Versions of the Gilliam Autism Rating Scale (GARS)," *Brain Sciences* 12, no. 5(2022): 537. doi:10.3390/brainsci12050537. Additionally, according to the World Health Organization an increase in disability continues due in part to the growth of noncommunicable diseases and a growing life span. See <https://www.who.int/news-room/fact-sheets/detail/disability-and-health>. According to the Institute of Medicine Committee on Disability in America, conditions such as asthma, prematurity, autism, and obesity are on the rise in children. *The Future of Disability in America*, ed. Alan M. Jette and Marilyn J. Field (Washington, DC: The National Academies, 2007), 66.

² Benjamin Zablotzky, Lindsey I. Black, et al., "Prevalence and Trends of Developmental Disabilities among Children in the United States: 2009–2017," *Pediatrics* 144.4 (2019): e20190811.

³ National Center for Education Statistics, "Students With Disabilities," in *Condition of Education*. (Washington, DC: U.S. Department of Education, 2024), <https://nces.ed.gov/programs/coe/indicator/cgg>.

⁴ Theologians and scholars across the spectrum agree with this assessment on the civilian side as well. See for instance, Stephanie O. Hubach, *Same Lake, Different Boat: Coming Alongside People Touched by Disability*, Revised and updated (Phillipsburg, NJ: P&R, 2020); Lamar Hardwick, *Disability and the Church: A Vision for Diversity and Inclusion* (Downers Grove, IL: IVP, 2021); Brian R. Brock, *Wondrously Wounded: Theology, Disability, and the Body of Christ* (Waco, Texas: Baylor University Press, 2020), 234; Amos Yong, *The Bible, Disability, and the Church: A New Vision of the People of God* (Grand Rapids, MI: Eerdmans, 2011), 16; Michael S. Beates, *Disability and the Gospel: How God Uses Our Brokenness to Display His Grace* (Wheaton, IL: Crossway, 2012).

⁵ Brock makes a convincing argument that lack of accommodations does not drive this absence, as the ADA mandated accessible buildings decades ago. Brock, *Wondrously Wounded*, 1. Nancy Eiesland makes a similar argument regarding accommodations, while noting few congregations make attempts at full participation for the disabled. Nancy L. Eiesland, *The Disabled God: Toward a Liberatory Theology of Disability* (Nashville: Abingdon Press, 1994), 20. All buildings on Federal property such as Army installations are required to meet these standards.

⁶ Melinda Jones Ault, "Participation of Families of Children with Disabilities in Their Faith Communities: A Survey of Parents" (PhD diss., University of Kentucky, 2010).

been part of amazing, loving chapel and church communities over the years, we have also experienced the pain of well-meaning, yet hurtful assumptions. I want to outline based on my personal and professional experiences the possible areas we must address to welcome disability families.

I explore the possible reasons families feel unwelcome in chapels and suggest some necessary steps to addressing the issue. To my mind, the work is more difficult than adding ramps or funding disability-equipped Child and Youth Services care during services. This work requires Chaplain Corps leaders to challenge biases and assumptions about the nature of disability.

I explore these assumptions through the major models of disability. Three primary models exist for understanding disability: the moral model, the medical model, and the social model.⁷ The moral model holds the sins of the individual with the disability or their parents are responsible for disability.⁸ The medical model focuses on curing the infirmity or adapting to society.⁹ The social model holds that disability is a social construct in which people with ableist bias determine normality.¹⁰ Assumptions and actions born from each of these models of disability can lead disability families to feel unwelcome. I explore each of these models briefly and provide examples of problematic actions and assumptions associated with each model.

The Moral Model

The moral model is most prevalent in the pews even as the social model is prominent in academia. Scholars and theologians widely condemn the moral model, yet many of its assumptions remain in the laity and even clergy.¹¹ The moral model has a long history. Throughout most of antiquity it was the primary lens through which people viewed disability. A shift away from it in many areas of society occurred post-Industrial Revolution.¹² The moral model view holds that parental action or sin result in disability. As a result, it tends to reduce many intellectual disabilities to a behavioral and discipline issue.

Moral model assumptions appear in both subtle and obvious ways. Comments connecting a child's condition to parental sins are among the more obvious. For instance, Christian author Michael Beates shares a

⁷ The moral model is sometimes referred to as the religious model and the medical model is sometimes referred to as the individual model. Jeff McNair, "Disability and Human Supports," *Christian Journal for Global Health* 2, no. 2 (2015): 10–15.

⁸ McNair, "Disability and Human Supports," 12.

⁹ Michael Oliver and Bob Sapey, *Social Work with Disabled People*, 3rd ed, Practical Social Work (New York: Palgrave Macmillan, 2006), 22.

¹⁰ Darla Y. Schumm and Michael Stoltzfus, eds., *Disability in Judaism, Christianity, and Islam: Sacred Texts, Historical Traditions, and Social Analysis* (New York: Palgrave Macmillan, 2011), 94.

¹¹ For example, John Swinton, *Becoming Friends of Time: Disability, Timefulness, and Gentle Discipleship*, Studies in Religion, Theology, and Disability (Waco, Texas: Baylor University Press, 2018); Eiesland, *The Disabled God*; Amos Yong, *Theology and Down Syndrome: Reimagining Disability in Late Modernity*, Studies in Religion, Theology, and Disability (Waco, TX: Baylor University Press, 2007).

¹² Helen Rhee, *Illness, Pain, and Health Care in Early Christianity* (Grand Rapids, MI: Eerdmans, 2022), 64.

heartbreaking testimony in *Disability and the Gospel* related to his severely disabled daughter. He laments how “well-intentioned but theologically obtuse believers have sincerely asked us if we had confessed the sin in our lives that must surely be responsible for her affliction.”¹³ Statements such as these cause incredible damage.

The comments may be less obvious, though they still betray a moral model of understanding disability. A dear friend with three disabled children was asked to help a chaplain start a disability ministry. This chaplain told him, “My kids aren’t special needs, but they certainly behave like it.”¹⁴ An individual once told me that my autistic son would “always be a problem” because his mother worked for the first two years of his life rather than remain in her “proper place” as a stay-at-home mother. The fact that most popular level parenting books do not address differences in families experiencing disability contributes to this understanding.¹⁵ These all betray moral model assumptions and unfortunately are not isolated incidents in communities of faith. They also are all quite hurtful.

Disabled children may act in ways that appear to the outside observer as discipline issues. For instance, lack of boundaries, inappropriate language, and aggression are common to several conditions. These children draw attention to their families in ways neurotypical or non-disabled children do not, often leading outsiders to assume the issue is a lack of discipline.¹⁶ This results in quiet judgement, awkward stares, and feelings of isolation. For instance, children on the autism spectrum can range from non-verbal to passive/aggressive and even violent. Individuals with neurological conditions often do not perceive the world the same way as the neurotypical.¹⁷ Many of their actions originate from a different perception of the world relative to neurotypical people, rather than a lack of discipline.

Sensory issues also cause significant discomfort that often leads to disruptive behavior. When a child’s sensory issue erupts during a worship service, parents often feel rejected by the responses of fellow parishioners. People

¹³ Beates, *Disability and the Gospel*.

¹⁴ While the vernacular of “special needs ministry” is often still used within chapel communities, it is generally considered offensive. Disability is used throughout this article. National Center on Disability and Journalism, “Disability Language Style Guide,” 2021, <https://ncdj.org/style-guide/#S>.

¹⁵ For instance, popular parenting method, *Shepherding a Child’s Heart* prescribes corporal punishment as the only acceptable method of discipline for children. Further, it insists that the parent must “spank” every time with no exception otherwise they are “sinning.” This is simply not available to many disability parents as it is counterproductive when the child lacks the cognitive ability to understand consequences on this level. One would also wonder if God is “sinning” when He does not “spank” His children for every sin. Tedd Tripp, *Shepherding a Child’s Heart*, 2nd ed (Wapwallopen, PA: Shepherd, 2005).

¹⁶ Laura Hendrickson, *Finding Your Child’s Way on the Autism Spectrum: Discovering Unique Strengths, Mastering Behavior Challenges*, New edition (Chicago: Moody, 2009), 33.

¹⁷ While the cause of Autism is unknown, the best evidence is that it is neurological and genetic. Simon Baron-Cohen, “The Cognitive Neuroscience of Autism,” *Journal of Neurology, Neurosurgery & Psychiatry* 75 (2004): 945-948. Proposed, though scientifically unproven causes range from a lack of attachment at early developmental ages (a clear indictment of parental action/ inaction) to sugar and gluten consumption. See “Beware Of Non-Evidence-Based Treatments - Autism Science Foundation,” Autism Science Foundation, Last modified 2020, <https://autismsciencefoundation.org/what-is-autism/beware-of-non-evidence-based-treatments/>.

stare, scowl, or even comment, whether audibly or under their breath. These reactions betray a failure to understand that a loud noise is an annoyance to the neurotypical, but to the individual with sensory issues, it can feel like a loudspeaker six inches from their ear. Uncomfortable clothes or seams on items of clothing may feel like fire on their skin. Judgment towards parents when their disabled children act out in response to these issues are the result of moral model assumptions. These reactions on the part of observers make families feel unwelcome in our chapels.

The pain experienced from moral assumptions about disability can be intense. A friend and fellow parent of a child with a disability summed up the pain, describing it as a humiliating suffering, rather than a virtuous suffering. Faith communities often hold up individuals with physical illness or suffering as pillars of virtue, especially when they overcome the obstacles. Those with mental impairments or limitations do not receive the same praise. When a disabled child becomes violent, elopes, or spits profanities in public settings, people often assume sin is to blame. The child's sinful heart led to the problematic behavior. The child, in reality may have little to no control over these reactions. When these behaviors occur in chapel, the judgment can be even more intense owing to the religious nature of the gathering.

Moral model assumptions must be confronted if disability families are to feel welcome in our chapel communities. As Nancy Eiesland laments, "As long as disability is addressed in terms of the themes of sin-disability conflation, virtuous suffering, or charitable action, it will be seen primarily as a fate to be avoided, a tragedy to be explained or a cause to be championed rather than an ordinary life to be lived."¹⁸ These assumptions about sin and disability project a judgmental and hostile environment to families with disabled members in our chapels. Before disability ministries can attract families impacted by disability with programs or services, leaders must address these assumptions.

The Medical Model

The medical model of disability developed out of the Industrial Revolution as an answer to the moral model and emphasizes independence versus dependence within society.¹⁹ The emergence of the medical model led to the institutionalizing of many with disabilities.²⁰ This represented a stark change from previous eras where people with disabilities were largely incorporated into society.²¹ The medical model assumes that the primary need for the

¹⁸ Eiesland, *The Disabled God*, 75.

¹⁹ Simi Linton, *Claiming Disability: Knowledge and Identity*, Cultural Front (New York: New York University Press, 1998), 29.

²⁰ Linton, *Claiming Disability*, 29.

²¹ Daniel Blackie, "Disability, Dependency, and the Family in the Early United States" in *Disability Histories* (Urbana, IL: University of Illinois Press, 2014), 20.

disability family is rehabilitation or a cure.²² While admirable in its desire to see physical improvement for an individual and the associated improved quality of life, the model ignores the need for integration and forms of care beyond the palliative. This individualistic model sees impairment as the only issue, suggesting societal adjustment plays no part.²³ The onus remains on the individual and their family to adapt and overcome.²⁴

The medical model and its assumptions extend beyond the medical industry. As Jeff McNair points out, “Special education teachers, rehabilitation specialists, physicians, and even those who pray for healing for someone may be basing their understanding of impairment on the notion that the individual with the disability owns the disability, and interventions need to be aimed at fixing the individual.”²⁵ McNair observes the emphasis is often on improving the individual, rather than improving the social group by incorporating people with disabilities fully. Amos Yong helpfully notes that this approach can cause people with disabilities to be “seen more as encumbrances than as viable members of ecclesial communities.”²⁶ As this model looks to erase disability, cures and rehabilitation are often the focus rather than acceptance.

This approach has practical implications for families affected by disability. Several years ago, my family visited a chapel with my autistic son who had a maladaptive event during the service.²⁷ I quickly moved him to the hallway to avoid disrupting the sermon any further. As we sat on the floor, our service dog cuddled him to ease his anxiety. From the cold, filthy floor covered in my son’s tears and his dog’s fur, I heard the chaplain preach on faith. His proclamation was that if we just had enough faith we could be healed. I could not help but wonder, where was our healing? I was prompted to reflect whether we have the requisite amount of faith for God to heal my son. I also wondered whether other parishioners, some who may suffer silently from mental illness, posttraumatic stress disorder, or other invisible wounds also lacked faith as well. What we heard was a simplistic, transactional view of God that thought the greatest need in our life was healing, when at that moment our greatest need was compassion.

22 Brian Brock, *Disability: Living into the Diversity of Christ’s Body*, Pastoring for Life: Theological Wisdom for Ministering Well (Grand Rapids, MI: Baker Academic, 2021), 44.

23 Oliver and Sapey, *Social Work with Disabled People*, 22.

24 Oliver and Sapey, *Social Work with Disabled People*, 24.

25 McNair, “Disability and Human Supports,” 12.

26 Yong, *The Bible, Disability, and the Church*, 113.

27 Sometimes commonly called “meltdowns” in the autism community, these are common occurrences that can stem from over stimulation to the senses or too many unforeseen changes to routine. These can involve screaming, extreme movements (stimming), or elopement. Hendrickson, *Finding Your Child’s Way*, 62.

Wonderful chapels have also been part of our family experience. My son would sometimes become agitated or loud while the senior chaplain was speaking at another chapel. The chaplain would laugh playfully and say, “Timothy, we love you and we’re glad you’re here!” That small gesture that acknowledged the reality of our family life affected us profoundly.

Medical model assumptions like moral model assumptions can cause significant hurt. Chapel communities miss the opportunity to connect with disability families when they assume that the greatest need is healing. These medical model approaches often lead to segregated disability ministries rather than integration, which recalls the institutionalized approaches of the past. Sometimes the greatest need is compassion and understanding, not cures.

The Social Model

The social model of disability holds that disability is socially constructed by able-body people to uphold the status quo.²⁸ What constitutes normal and able are determined by social values.²⁹ Under this model, society creates disability as a form of “othering.”³⁰ Society is seen as maliciously discriminating against the disabled to promote its own agenda and wellbeing.³¹ Today this view represents the dominant viewpoint in academic disability studies.

Those who adopt this understanding make helpful observations yet can take an activist approach towards those with disabilities.³² These families can become “projects” or interest groups, rather than real people with real issues. While many in the disability community embrace the activist role, others reject it because of how it draws attention to the family. The non-disabled family enjoys the option of going unnoticed, while the disabled family does not. The social model itself does require society to change to accommodate its disabled members. The model, though, can also place a burden on the disability family to be voices of change.³³ Furthermore, the model separates the idea of disability from impairment, in a way that may minimize the tangible and objective impact of the conditions. Under the model, impairment is the physical or tangible condition that impacts the individual while disability is a social construct. Amos Yong speaks from this perspective to suggest, “Indeed, the tragedy and evils of disability have less to do with the biomedical conditions of human bodies than with the

²⁸ Linton, *Claiming Disability*, 11.

²⁹ Schumm and Stoltzfus, *Disability*, 94.

³⁰ Colin Barnes and G. Mercer, *Exploring Disability: A Sociological Introduction*, 2nd ed (Malden, MA: Polity Press, 2010), 1.

³¹ Barnes and Mercer, *Exploring Disability*, 6.

³² Pluckrose and Lindsay, *Cynical Theories*, 162.

³³ Gary E. May, “The Disability Discrimination Model: Changing the Future of Disability” in *Ending Disability Discrimination: Strategies for Social Workers* (Boston: Pearson Allyn and Bacon, 2005), 93.

social repercussions of an ableist and normate bias.”³⁴ While this observation highlights many of my claims, the tangible impact and pain of the impairment may be minimized when society is seen as the primary source of the tragedy.

The social model is helpful as a step towards necessary change in communities, but it still falls short. The shortcomings are unhelpful assumptions that can further isolate families. The social model tends to ignore the reality of physical suffering in favor of changing societal expectations. While integrating people with special needs into the chapel is a noble goal, it cannot be done at the expense of acknowledging the real sufferings they endure. The pain is not always social. Additionally, chapels will tend to treat families with disability like an interest group under this model, rather than members.

The Way Forward

The task before chapel communities is significant, but achievable. The work involves the time-consuming activities of self-reflection and critical analysis, in the service of positive change. Multiple models may concurrently influence our thinking on disability. There is no one model of approaching disability that addresses every concern. This article outlines ways how disability families are made to feel unwelcome, but there are bright spots on which to build. Integration happens at the local level and assumptions change through relationships with disability families. Change on the relational level can be aided by the tone and priority of senior leaders.

The Chaplain Corps must embrace a positive, integrated vision for disability ministry in its chapels to see change. This strategic vision should include an end state where families with disabilities are not only integrated and understood, but also embraced. The vision must communicate the value of disability families, rather than just their needs. Attracting these families with specialized disability ministries such as dedicated childcare during services will not work unless they feel valued.

Chapel leaders should seek to understand what makes people with disabilities feel unwelcome and resource positive change beyond the program level. For instance, ask what congregations believe about disability and challenge the misconceptions. Chaplains are religious leaders with an obligation towards a compassionate understanding of disability and suffering. Teaching and preaching on the value of this community can shape the congregation's understanding and attitudes towards disability families. Consider working through books such as Stephanie Hubach's *Same Lake, Different Boat*:

³⁴ Amos Yong, *The Bible, Disability, and the Church*, 12.

Coming Alongside People Touched by Disability or Brian Brock's *Wondrously Wounded*. Each comes from a different perspective and raises crucial questions for leaders' views of disability.

Integration is also key to disability ministry. When the social roles of people with disabilities are valued, they experience more outcomes that are positive.³⁵ A ministry that only provides specialized care during a service sends the message that these individuals are not valued, because they are isolated from the community. Integrating them into the service or discipleship ministry with non-disabled individuals is often preferable. This inclusion prevents disability families from feeling isolated. In certain cases, with severe disabilities, this might not be possible. However, the general truth remains that integration should be the goal.

On a practical level, facilities can be adjusted to allow disability families to participate in the service from other rooms should the need arise. However, a word of caution: families cannot be pushed off to the sidelines. These rooms must not feel like isolation. Occasionally, I sit in the lobby with my son when he struggles to be in the service. Where we attend, there are several comfortable couches and a screen with the service livestreamed. What is most helpful however, are the people who linger in the lobby, which makes us feel welcome. They stop to talk while the service is ongoing and they directly acknowledge my son. In this way, they keep us from becoming isolated. This is not a sophisticated program, but a relational approach that must be taught, modeled, and valued by and within the congregation.

Conclusion

The most productive and difficult task in welcoming disability families might be self-reflection. We as religious leaders must ask ourselves the hard questions: how do I view this family, what are the assumptions I make about disability, and what message am I sending with my words? They must be valued beyond the desire to meet the needs of a group within the community.

The assumptions outlined above represent a starting point for reflection. Moral model assumptions can be among the most damaging and hurtful to disability families. Parental guilt is already a significant issue for disability families.³⁶ The chapel community must avoid adding to that concern through moral model assumptions. Medical model assumptions tend to limit efforts to accommodation rather than integration, focusing primarily on meeting perceived needs. Social model assumptions tend to see relationships through the lens of discrimination. Families with a disabled member deserve better

³⁵ Jeff McNair and Marc Tumeinski, "What Would Be Better? Social Role Valorization and the Development of Ministry to Persons Affected by Disability," *Journal of the Christian Institute on Disability* 9, no. 1 (2020): 158-68.

³⁶ Helen Tager-Flusberg, "Should Scientists Study Mothers of Children With Autism?", *The Transmitter*, April 12, 2016, <https://www.thetransmitter.org/spectrum/should-scientists-study-mothers-of-children-with-autism/?fspec=1>.

from religious leaders than these assumptions. They deserve to be valued and integrated within our Army chapel communities, free of judgement and cliché understandings.

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