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Adult Education and Disability

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Disability is a relatively recent and contentious term. The nomenclature used to refer to those *debilitated* or *diseased* has evolved from *handicapped* or *disabled people* to *people with disabilities* (Rocco & Delgado, 2011). Yet, some question the use of “people first language” when we don’t say “person with a gender or race” (Rocco & Delgado, 2011, p. 8). Meanwhile, bearers of bodily, cognitive, and mental difference are reclaiming *mad*, *cripple*, and *disabled*, and an array of other signifiers and embracing them not just as descriptors but as badges of pride.

Traditional Perspectives on Disability

While disability been largely overlooked in the literature of the field, where they appear, conceptions of disability within the field have been influenced over time by the educational setting, legislative mandates, and perspectives on disability prominent in related fields. Over the last several decades different models have been used to understand disability and its relationship to educational policy, best practices, and global concerns, each with different assumptions and emphases.

Medical Model of Disability

The foremost model of understanding disability remains the medical model of disability that posits how bodily, cognitive, and mental variations are grounded in one’s genetics and individualized within its bearer (Oliver & Barnes, 2012). These variations

are presumed to follow from bad biology or biochemistry, disease, or trauma and inhibit the full physiological, mental, or cognitive functioning of those deemed disabled. This model regulates bodily/mental “otherness” and entreats the sick, ill, and debilitated as “deficient” and “less than” (Beresford & Menzies, 2015). It stresses the need for intrusive treatment and cure regimes to remedy illness and disability through biomedical fixes. Through the 1960s and into the early 1970s, medical perspectives were dominant as the framework for understanding disability in related fields including special education, rehabilitation, and vocational education (Rocco & Fornes, 2010). Discussions of disability focused on clinical and psychoeducational assessments to diagnose physical, cognitive, or mental conditions, viewed as impairments to be addressed by medical procedures, medications, or psychoeducational interventions.

Functional Model of Disability

In some ways, the functional model mirrors the medical model by conceiving of disability as arising from “deficits” in one’s physiological, psychic, or cognitive makeup. This model relates that the limitations these disorders impose on those differently abled prevent them from engaging in life-fulfilling activities such as employment or education (Rocco & Fornes, 2010). Adult educators will likely be familiar with Section 504 of the Rehabilitation Act and the Americans with Disabilities Act of 1990 (ADA), both of which can be viewed as reflecting a functional model of disability.

According to the Rehabilitation Act of 1973 “[a]n ‘individual with a disability’ is a person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment or is regarded as having such an impairment” (Section 504 of the Rehabilitation Act). Almost 20 years later, Congress enacted the ADA as an extension of the Rehabilitation Act. The ADA is a broad civil rights law prohibiting discrimination in all areas of public life, including jobs, schools, transportation, and all public and private places, utilizing the same definition for individuals with disabilities as the Rehabilitation Act. Title I of the ADA, focuses on equal opportunity in employment and so has implications for adult education in the workplace. Title II prohibits discrimination against qualified individuals with disabilities in all programs, activities, and services of public entities. Title III, on the other hand, applies to “private places of public accommodation” (ADA National Network, 2017), and therefore has implications for private organizations offering educational opportunities for adults. Essentially, then, all public and private organizations providing adult education are expected to be accessible to students with disabilities. The ADA Amendments Act of 2008 (Public Law 110-325, ADAAA) was intended to make it easier for an individual seeking protection under the ADA to establish that he or she has a disability. In ACE literature, disability tends to be discussed through the prism of functional and medical models (Rocco & Fornes, 2010). Adult educators and systems of higher education then consult these models to engage with or accommodate students with diverging bodies and minds (Fernando, 2016). Adult educators are beginning to rethink categories of disablement using critical theory (Rocco & Delgado, 2011; Rocco & Fornes, 2010).

Contemporary Perspectives on Disability

Disability studies grew out of disability rights activism in the United States and Europe. This activism shifted the focus from medicalizing disability as a personal pathology to be treated and cured, to understanding body and mind variance as a political and social cause for concern (Ross-Gordon, 2017). Disability studies maintains that: a) persons with disabilities (PWD) are marginalized; b) constitute a minority group; and

c) disability should be rethought as a social problem (Roulstone et al., 2013). Disability studies does not appeal or speak to all PWD; for instance, this discipline hardly ever refers to “madness” (Rose, 2017).

Mad studies was, in part, created to address this lacuna. Mad studies entered into the academy via departments of critical disability studies (LeFrançois et al., 2016); yet the infiltration of mad studies into disability studies continues piecemeal (Jones & Brown, 2013). Mad studies is an “exercise in critical pedagogy—in the radical coproduction, circulation, and consumption of knowledge” (Menzies et al., 2013, p. 14). The purpose of mad studies is bifold: a) to counter the hegemony of biopsychiatry and to dispute that distress and madness has its origins in genetics; and b) to restore power and epistemic voice to people who have been diagnosed or labelled as mentally ill (Menzies et al., 2013). Mad studies bears “mutual affinities” with disability studies (Gorman, 2013) insofar as both counter pathological models of disablement and discuss disablement from a critical stance rather than a clinical one.

Social Model

Created as an alternative to the reductionist medical and functional paradigms, the social model of disablement redirects the blame from one’s bodily, cognitive and mental composition to their socio-economic surroundings (Goodley, 2011). The social model severs “impairment” from “disability” and supposes that disabilities are the oppressions layered on top of or attached to impairments (Procknow & Rocco, 2016). Social model theorists accept “impairments” as functional limitations. No social meaning is imputed to impairments (Withers, 2012). The radical model of disability is dissimilar from the social model inasmuch as both “impairments” and “disabilities” are viewed as socially constituted (Withers, 2012). This model argues that there is no biological cause for impairments. That having been said, the social model was created with only people with physical and cognitive disabilities in mind (Withers, 2012). While the social model does not entirely attend to mad matters, a revised social model—the social model of mental distress and illness—considers issues that are specific to self-identifying mad people (Beresford et al., 2010). The social model of mental distress is not a replacement, but an extension of the social model of disability (Beresford et al., 2012).

Discussions of adults with disabilities embedded within a social model of disability place greater emphasis on factors inherent to discrimination against those whose physical, cognitive, and mental characteristics or capacities are different from what is viewed as normal—calling out attitudes of ableism and sanism on the part of others (McRuer, 2013; Poole et al., 2012). *Ableism* involves “discriminatory, oppressive or abusive behavior arising from the belief that disabled people are inferior to others” (Miller et al., 2004, p. 9). Further to this, *sanism* is regarded as the discrimination and the mental “othering” of those maligned as “mad” or “crazy” and those branded with psychiatric diagnoses (Diamond, 2013). Ableism and sanism are invisible, pervasive, and forms of disability oppression (Perlin, 2008). Like ableism, sanism can be the cause of, or reflected in other “prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry” (Perlin, 2008, p. 590).

Selected discussions in disability studies and mad studies move beyond the social model to include the wider and layered imbricated social categories of identity that are imprinted on disabled bodies and minds (Ross-Gordon, 2017). Interestingly, both studies consider that two or more marginal identity markers can be collocated in one body as with: *gender*—using feminist disability studies to reimagine the possibilities when nesting feminism within disability studies rather than merely blending the former into the latter (Garland-Thomson, 2005); *race*—whereby, racial, diasporic and disabled citizens of the Global South have found little resonance with a “White” disability studies (Bell, 2011) or mad studies (Gorman, 2013); and *sexual orientation*—queering disability studies by using analogies critically to twine queer identity and disabled identity through their comparable experiences of “coming out” (McRuer, 2013).

Biopsychosocial Model of Disability

Shakespeare (2012) points to the need for a multifactorial or integrated approach to disability. Although he critiques interpretations of the social model that minimize impairments, he acknowledges that environments are disabling to people with impairments. Thus, he contends that “adequate accounts of disability should make space for medical, psychological, social, and political factors in the lives of people with disabilities (p. 129).

Building on this biopsychosocial model of disability, the World Health Organization has developed the International Classification of Functioning, Disability, and Health (ICF), a tool intended as a way of classifying the functioning, disability, and health of individuals worldwide. Disability is viewed as:

a complex phenomena [*sic*] that is both a problem at the level of a person’s body, and a complex and primarily social phenomena. Disability is always an interaction between features of the person and features of the overall context in which the person lives, but some aspects of disability are almost entirely internal to the person, while another aspect is almost entirely external (World Health Organization 2002, p. 10)

This tool is intended to assess both personal and environmental factors, so that appropriate interventions can be individually designed. Adult educators who similarly argue for holistic, interactional, or integrative understandings of disability incorporating biological, psychological, cultural, and sociopolitical dimensions of the experience of disability include Rule and Modipa (2012) and Ross-Gordon (2017).

Only a few academics have cross-fertilized AE with disability studies (Clark, 2006; Rocco, 2005). Thus far this examination has indicated that: (a) rarely does disability ever enter centrally into discussions of workplace learning (Procknow & Rocco, 2016); (b) teaching about disability studies in education is an ethic of responsibility where educators are called on to dismantle structural ableism (McLean, 2011); (c) some impairments are “deemed more amenable to education than others” (Goodley, 2007, p. 320); and (d) certain bodies and minds are bestowed more access to disability supports (Liasidou, 2014).

Traditional Approaches to Psychoeducational and Training Needs of Adults With Disabilities

As defined by Donker et al. (2009), “psychoeducational interventions are interventions in which education is offered to individuals with psychological disorders or physical illnesses” (p. 2). While their meta-analysis focused on psychoeducation for depression, anxiety, and psychological distress, psychoeducational

interventions have empowered women with chronic physical disabilities (Vail & Xenakis, 2007), developed life skills in incarcerated individuals with learning disabilities (Hearne et al., 2007), and assisted formerly homeless individuals with co-occurring mental illness and substance abuse through various transition programs (Sun, 2012).

Adult Basic Education and Literacy Programs

Adults with disabilities have long been a focus within the context of adult basic education literacy practice, although with few exceptions (Moni et al., 2011; Silver-Pacuilla, 2006) this discussion has focused on adults in literacy programs *known or suspected* to have specific learning disabilities (Belzer & Ross-Gordon, 2011). Much of this literature has focused on identifying effective instructional strategies for improving basic skills performance (Hock, 2012; Mellard & Scanlon, 2006; Pannucci & Walmsley, 2007), while another prominent strand focused on assessment issues (defining learning disabilities, determining the prevalence of learning disabilities, and screening for learning disabilities in adult basic education programs) (Reynolds et al., 2012; Taymans, 2012). Yet, Covington (2004) cautioned adult basic education teachers and administrators that “Danger arises when this label—or any other label—serves the needs of those who apply it at the expense of those who receive it” (p. 101) and suggested instead that “By incorporating a variety of strategies in an emotionally safe and accepting environment, teachers will help not only those with learning disabilities, but all students” (p. 100). Similarly, in an analysis of the limited research examining instructional and testing accommodations made for learning with learning disabilities within adult basic education, Gregg (2012) first points to the limited use of accommodations in this setting and evidence of their effectiveness when used, then calls for greater use of universal instructional design likely to benefit both those with diagnosed learning disabilities and the many adults in basic education who cannot afford the cost of evaluation procedures needed to acquire the documentation required for accommodations.

Accommodations Within Higher Education

Within higher education, the predominant provision for learners who qualify as disabled under ADA and Section 504 of the Rehabilitation Act has been through instructional accommodations, coordinated

through an office for disabilities services (Oslund, 2015). Students are sometimes reluctant to seek accommodations, given their desire to avoid stigmatization they have experienced in the past (Couzens et al., 2015). Others struggle with securing the requisite documentation needed to access disability supports, given these costs are not covered by the institution. Furthermore, nonvisibly disabled students are least likely to be believed by their instructors due to the disablist “assumptions at play in accommodation policies” (Landry & Church, 2016, p. 180). Recalcitrant professors may deny students requests for support or riddle the request process with so many hurdles that students may not receive accommodations before the class ends (Poole et al., 2012). In some instances, disability disclosures are made too late in the semester or surface only when students are at risk for flunking (Summers, 2008).

Job-Related Accommodations and Training

Shortages in job training to remedy disabled employees’ skills deficits continues to hamstring their job growth (Augustin, 2011). Even when training occurs, disabled learners are disadvantaged by exclusionary curricular aspects, such as handout materials printed using small fonts (Procknow & Rocco, 2016). For ADA protection to apply, the employee should communicate their need for accommodation before the training begins (Clardy, 2003). Where group training fails to include disabled learners, then personalized training and development should be offered. Personalized workplace learning for workers with intellectual disabilities can enhance job performance and empowerment (Fornes et al., 2008). Supplying cognitively impaired workers ongoing training and maintenance of job skills can lessen their chances of turnover (Fornes et al., 2008).

Moving Beyond Traditional Approaches: Promoting Greater Disability Inclusion and Equity Across Sectors of ACE

An alternative or supplementary model to providing educational and workplace accommodations to those who qualify under ADA and Rehabilitation Act 504 is the creation of courses, programs, and worksites that are designed for greater inclusion. The next section discusses ways in which ACE can nurture diversity,

inclusion, and equity for PWD within and beyond the academy.

Inclusive Education

ACE educators can model openness and inclusion by accepting students who bear mental, cognitive, and bodily variance and altering the environment to better meet their needs. Citing Nirje's *normalization principle* (1969) as the origin of the concept of inclusion, Renzaglia et al. (2003) suggest that

individuals both with disabilities and without disabilities must acquire skills needed for living and learning in inclusive settings. These skills include those needed to interact with each other, support each other, cooperate with each other, and complement [*sic*] each other's strengths. (p. 141)

For instance, openness involves educating able-minded students to be tolerant of students in insane states of mind and their ways of being and knowing in the world (Burstow, 2003).

Inclusive educators confer credence to students' claims to alternate realities, as for example, students who hear voices (Burstow, 2003). Students who are divergent from what Garland-Thompson (1996) termed the *normate*—those with unmarked privileges of White, male, cisgender, heterosexual, able-bodied, and middle-class bodies—will feel included when they sense they are adequately represented. Increased representation communicates to learners with mental, physical, and cognitive disabilities that community exists within the university and that they no longer need to “go it alone” (Poole & Grant, 2018). ACE endorses the equity of students in mad or distressed states of mind by rethinking what constitutes healthy states of behaving and being. This includes destabilizing categories of sanity as the ideal state of neurodiversity. Adult educators need to start to rethink how able-bodiedness, neurotypicality, and saneness are reified in their pedagogical praxis as normative and, specifically, how hegemonies of saneness exclude students that experience its obverse, insanity.

Adaptive Leadership

Disabled students need to know that their teachers are receptive to their need to be included. *Adaptive leadership* is a style of leadership that demands leaders adapt to disabled persons' debilitated minds and

bodies (Anderson et al., 2015; Maxey et al., 2016). Instructors assuming this leadership style adjust to the divergence of their students' experience in cognition, mental, or physical functioning (Maxey et al., 2016). Adaptive leadership is similar to the social model of disablement, inasmuch as environments are expected to adapt to and accommodate student disabilities. Instructors exhibiting adaptive leadership work collaboratively with students in identifying and solving complex problems (Anderson et al., 2015). For example, teachers that exercise adaptive leadership in class reorient their praxis to become *mad positive*; to practice mad positivity is to not identify as “mad” but “support [the] goals of those who do” (Reville, 2013, p. 170). Mad positive teachers enact “mad-enabling pedagogies” (Castrodale, 2017). These “pedagogies” guide teachers on how best to bring about mad positivity in the classroom by dialoguing about recovery, nonpsychiatric alternatives, peer support, and allowing for mad subjectivities to be shared. In mad-positive classroom cultures, madness is rethought of as only one tile in a mosaic of marginality (Castrodale, 2017).

Universal Design

Universal design (UD) approaches constitute one means of minimizing barriers for individuals with varying types of minds and bodies. Originating in the field of architecture, UD is a way of designing a building or facility so it is attractive and functional for all people, disabled or not (Hamraie, 2013). *Universal design for instruction* (UDI) is a modification of UD. Scott et al. (2003) developed the nine principles of universal design for instruction—including equitable use (concerned with accessibility to a broad range of individuals), flexible use (to accommodate individual abilities), and a welcoming instructional climate.

More recently, the focus has turned to universal design for learning (UDL) (Rogers-Shaw et al., 2018). Like UDI, it shifts the focus from the student with disabilities to the “disabled curriculum” (Rappolt-Schlichtmann et al., as cited in Rogers-Shaw et al., 2018, p. 23). The Center for Applied Special Technology (CAST) interprets UDL in terms of providing multiple means of engagement, representation, and action and expression for learners, and has developed guidelines for UDL, presented in the form of an evolving graphic organizer (CAST, 2018). UDL enables students to access flexible learning environments. First, flexibility is structured into the design

of the curriculum, permitting the loose attendance of students (Burstow, 2003) or scheduling classes for the afternoon to accommodate mad learners that deal with the residual effects of neuroleptics such as lethargy in the morning (Poole & Grant, 2018). Second, instructors grant flexibility when it comes to completing assignments, for example, allowing coursework alternatives if requested (Castrodale, 2018; Jones & Brown, 2013) or extensions on due dates (Poole & Grant, 2018). UDL has been touted as offering pedagogical practices to adult educators which benefit all adult students “with a lack of language fluency, or with weak basic skills” who struggle in formalized educational settings (Rogers-Shaw et al., 2018, p. 22). Yet, universal design concepts are not without their problems. There are concerns that universal design does not avail all mad learners equally. White, mad-identified students are more “likely to be registered with disability services than students of color” with comparable behavioral or emotional disturbances (Gorman, 2013, p. 279). For these reasons and others, Gorman (2013) maintains that mad identity is articulated as a position of privilege and that this privilege redounds to White mad students the greatest benefits and access.

ACE has also taken steps towards developing communities supportive of differently abled bodies and minds outside the academy (Fernando, 2016). For instance, mental health service providers have enlisted the help of outpatients as “coproducers” to deliver destigmatization campaigns and community mental health awareness workshops alongside clinicians (Ledger & Slade, 2015). To involve service users in the coproduction of educational programs is in line with ACE, disability studies, and mad studies insofar as coproduction privileges the frenetic voices and realities of said users. In a different vein, “advocates” are nested within user/survivor activist circles and the academy, where their pedagogy informs their community praxis (Landry & Church, 2016; Reville, 2013). They teach *with* community rather than about community (Castrodale, 2018)—this “requires a special pedagogy that brings students to the community and brings mad people into the academy” (Faulkner, 2017, p. 515). Similarly, adult educators can create pathways back to academia for those with diagnosed mental disorders through supported education (SE). SE eases mentally ill learners (re)entry (back) into college or university following hospitalization to redress skills and capacity shortages (Fernando et al., 2014).

Supporting Self-Determination and Self-Advocacy

Early activists paved the way for an ongoing social movement that has contributed to key policy changes such as ADA, and which continues today through the work of organizations such as the American Association for People with Disabilities (AAPD, 2018), Self Advocates Becoming Empowered (SABE, 2020), and the Hearing Voices Network (HVN, 2020). For example, Faigin and Stein (2015) studied individuals with psychiatric disabilities who served as actors in theater troupes performing works about mental illness and recovery, designed to educate as well as entertain audiences. Study findings revealed actor-participants experienced personal growth as well.

Ryan and Griffiths (2015) examined the literature on self-advocacy from a transformational learning perspective. They uncovered personal impacts of self-advocacy, including growth in leadership abilities and changes in self-concept. They also discovered impacts on advocacy advisors, who improved their capacities to play a supportive rather than a directive role in working alongside adults with intellectual disabilities. Finally, they identified positive impacts on boards and communities that took seriously the input of self-advocates with disabilities.

Similarly, in studying transitions of secondary students to postsecondary education and work, Wehmeyer et al. (2018) present evidence of enhanced well-being and functioning resulting from the use of a strengths-based approach to disability, grounded in positive psychology and an ecological model of disability. They argue for a paradigm shift from the disability services systems nearly ubiquitous in postsecondary education, to a personalized supports paradigm. This model places more emphasis on self-determination, “as enabling people to act as causal agents in their own lives becomes an important means to enable people to live, learn, work, and play in their communities. People with disabilities become, in essence, their own supports” (Wehmeyer et al., 2018, p. 57).

Implications for ACE Research and Practice

We would be remiss to end this chapter without including recommendations for ACE research and practice. The literature reviewed for the chapter has drawn from related fields including disability studies and mad studies. This points to the urgent need for research

focused on adult education and PWD. While historically much of the writing on disability from within the field has been based in medical and functional models of disability, it is important that those doing research today also incorporate social, radical, ecological, and integrative models of disability. It is equally important that adult education and training move beyond simply accommodating PWD as required by legal mandates, to incorporating principles of universal design (UD, for environments), UDI (for instruction) and UDL (for fostering self-determination and self-advocacy among learners who are PWD). In order to reduce disability-based discrimination it is important that educational interventions extend beyond PWD alone, to educate members of the public, employers and potential employers, and last but not least, ourselves as adult educators. The consequences of ableism and sanism lead to significant loss of human potential. Thus, it is crucial that through formal and informal professional development we become more aware of these “-isms,” as well as others compounding the negative impacts for individuals with intersectional identities, starting with the examination of our personal biases and their potential impact on our educational practice.

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