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Coming to Critical Disability Studies: Critical Reflections on Disability in Health and Social Work Professions
En venir aux études critiques du handicap : réflexions critiques sur le handicap dans les professions de la santé et du travail social

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Abstract

This paper describes how four ‘helping’ professionals came to embrace and teach critical disability studies (CDS) perspectives rather than biomedical approaches to impairment and disability that traditionally inform those professions (occupational therapy, physiotherapy, social work, and speech-language pathology). Sharing examples from our experiences, we describe how we came to question the normative, ableist assumptions of our professional disciplines. We then briefly outline literature demonstrating how critical approaches have been incorporated into professional research and practice and discuss possible obstacles and tensions in adopting more widespread critical approaches into professional spaces. We conclude by suggesting that continued development of connections among scholars and activists within CDS, rehabilitation and social work, and the community, is necessary to ensure that intersectional critical perspectives in relation to disability become a core component of professional training programs.

Résumé

Cet article décrit l'évolution de quatre professionnelles « aidantes » vers l'adoption et l'enseignement des perspectives d'études critiques du handicap plutôt que des approches biomédicales des incapacités et du handicap qui façonnent traditionnellement ces professions (ergothérapie, physiothérapie, travail social et orthophonie). Grâce à des exemples de nos vécus, nous décrivons ce qui nous a menés à remettre en question les hypothèses normatives et

capacitistes de nos disciplines professionnelles. Ensuite, nous décrivons brièvement la littérature démontrant la manière dont les approches critiques ont été incorporées dans la recherche et la pratique professionnelles et discutons des obstacles et des tensions possibles freinant l'adoption d'approches critiques plus largement dans les espaces professionnels. En conclusion, nous suggérons qu'il est nécessaire de développer en continu des liens entre les universitaires et les activistes au sein des études critiques du handicap, de la réadaptation et du travail social, ainsi qu'avec la communauté, afin de garantir que les perspectives critiques intersectionnelles relatives au handicap deviennent une composante essentielle des programmes de formation professionnelle.

Key Words

Critical disability studies; disability studies; rehabilitation; social work; health professionals; reflection; professional education

Introduction

Traditional health and social service professions such as social work, occupational therapy, physiotherapy, and speech-language pathology have historically positioned disability as a condition of ‘lack’ located in people’s minds and bodies. Understanding disability as a problem requiring intervention by experts to successfully meet standards of normalcy allows for and justifies these professions’ existence (Illich et al., 1977; Oliver, 1990), and the ongoing centrality of rehabilitation and social work within Global North approaches to disability reflects the continuing priority given to ameliorating the ‘problem’ of disability (Campbell, 2009; Clare, 2017; Siebers, 2011; Stiker, 1999). From a historical perspective, the emergence of rehabilitation and social work professions overlaps closely with socio-political constructions of the various conditions they purport to treat (Bransford, 2011; Ruty et al., 2005; Trent, 1994).

Contrary to traditional approaches, critical disability studies (CDS) scholarship recognizes disability as a socio-political phenomenon, while examining the relationship between the body, mind, and society. CDS seeks to question societal ideals of normalcy, and considers how social and bureaucratic obstacles, and the ableist interpretations of difference on which they are based, create inequitable access to societal structures. It recognizes too that disabled people may not consider themselves as being in need of ‘fixing’ (Clare, 2017). These critical interpretations of disability disrupt the person-as-problem ideology and problem-fix continuum upon which rehabilitation and social work professions depend. Acknowledging that disabled people’s concerns are influenced by other social marginalities and often have more to do with political and economic circumstances and the social oppression they encounter than with particular bodymind difference¹

¹ We use the term bodymind difference throughout this paper as a move away from traditional impairment terminology and the negative valuation of difference. In doing so, we follow Clare’s lead to resist distinctions between normal and abnormal and point instead to “the non-negotiable value of that difference” (Clare, 2017, p. xvii).

(Burghardt, 2018; Clare, 2017) forces a re-framing of the usefulness of the ‘helping’ professions and how they carry out their work. Indeed, scholarship from the disability studies canon has historically and consistently indicated an urgent need to challenge the prioritization of social work, rehabilitation, and other ‘professional’ interventions in the lives of disabled people (Oliver, 1990; Stiker, 1999).

The four authors² of this paper have all journeyed from roles in traditional professions (occupational therapy (OT), speech-language pathology (SLP), social work (SW) and physiotherapy (PT) respectively) and the relations with disabled people those professions espouse, to critical stances that counter the problem-fix narrative and recognize disability as a political status. All of us, initially attracted to our professions’ promise of helpfulness and altruism, soon encountered situations in which our respective practices failed to address what disabled people identified as most urgent and relevant to their lives. The lack of applicability of some of the precepts of our professions provoked a desire for more critical and nuanced understandings of disability and the priorities of disabled people.

In this paper, we describe our journeys from rehabilitation and social work professionals to critical disability studies scholars. Individually and collectively our relationship to disability is multiple and varied. We are disabled and non-disabled scholars who teach and do research with disabled activists, community members, and other disability-positive scholars. We discuss our transition from ‘professionals’ imbued with a sense of helpfulness, through periods of discomfort as we came to recognize our professions’ limitations; our grappling with these limitations and the questions they generated; and our embrace of an approach that critiques and problematizes constructions of normalcy and disability, with considerations of what such an approach might

² Please note that all authors contributed equally to this manuscript.

mean for disabled people and our respective professions. We have all left professional practice, and some of us have moved into the teaching *of* practice, struggling for years to find a place teaching and ‘doing’ CDS in non-CDS spaces. As we discuss this transition, we share examples from our experiences, specifically our encounters with disabled people wherein we recognized the need for more robust, nuanced, and political critiques and interpretations of disability within our professions.

Experiences of Disquiet with Professional Knowledge and Practice: Encountering Critical Disability Studies

Even in the early stages of our respective practices, we all found ourselves in situations in which we encountered limits to what our professions could offer to the people we were purportedly ‘helping’. These encounters led to a sense of “disquiet” (Smith, 1999, p. 3) with the theoretical frameworks and practices of our disciplines, and which led to critical reflection and coming to CDS. In this section, we explore three of these professional limits through a retelling of our experiences: a lack of applicability to the realities of disabled people’s everyday lives; a limited presentation of the complex political and social realities with which disabled people live; and a limited medical view of disability resulting in ongoing attempts to ‘normalize’ disabled people.

First, through various encounters both at work and in the community, we began to realise what we had been taught as essential to our practices was frequently unwarranted or irrelevant to the lived experiences of the people with which we engaged. The ‘textbook’ learning, and even the practicums that were primarily experienced as encounters between students from a sheltered

university program and ‘clients’³ in a supervised learning environment, did not prepare us for what was lived by these same people beyond the walls of scholarly and medical institutions. Within our practicum placements, both the social construction of clients’ ‘problems’, as well as real-life obstacles and experiences often remained invisible.

For example, Karen Yoshida found herself reflecting on her role as a physiotherapist after an incident that occurred during her 1982 clinical internship at a spinal cord injury rehabilitation centre. Karen’s practicum supervisor tasked her with teaching a patient with quadriplegia how to transfer from wheelchair to toilet. After studying from a standard textbook on transfers to prepare for the task, she met the client, Brian (pseudonym), in the washroom the next day. Upon entering the stall, it became apparent that the information from the textbook was not going to help her teach Brian how to transfer onto the toilet. Feeling foolish, she asked him what he needed in order to do this transfer, and he replied matter-of-factly, “I will probably use a Hoyer lift”. The text she had studied to provide her with the professional knowledge to instruct Brian was inapplicable in practice and contributed little to Brian’s ability to safely use the washroom, while Brian already had the knowledge of what was needed for him to transfer safely. The unreceptive professional text of ‘knowledge’, while bound and seemingly impermeable and unquestionable (Titchkosky, 2007), was disrupted by the everyday reality of Brian’s situation and his own knowledge of the capabilities of his body. Brian’s everyday experiences and his knowledge of his body’s capabilities invalidated the bound, seemingly unquestionable professional knowledge usually relied upon in professional-client encounters (Titchkosky, 2007).

³ Interspersed throughout this paper are professional terms used to identify disabled people who voluntarily or involuntarily receive services from SW, PT, OT and SLP professionals, for example, ‘client’ and ‘patient’. When used, these terms are indicative of language used in the space and time addressed in the authors’ reflections.

In another example of how therapeutic activities are not always relevant to people's lives, Karen challenged the mundane nature of a group exercise for individuals with quadriplegia during her clinical placement. She was asked to lead a typical shoulder exercise class using canvas slings hanging from the ceiling. After helping each person put their arms into a sling with their arms held in the air at about 90 degrees, she found herself looking out at everyone and envisioning how medieval prisoners were chained, with arms raised, to the cold stone walls in towers. She thought these participants were also imprisoned, not by their bodies in wheelchairs, but by the therapy being provided to them. While conducting the class – asking people to do various movements in the sling – both she and the attendees lacked enthusiasm for the exercises, and she felt uncomfortable and embarrassed. Although helpful to maintain the shoulder, she questioned whether there was something more interesting that could be done instead. She proposed to her supervisor to conduct another class using karate arm moves of blocking and punching and how to deflect kicks, as she was a black belt practitioner at the time. Twice as many people showed up for this announced 'self-defence' class than the 'shoulder exercise class'. The participants enjoyed using their whole body in a fun, meaningful way, and left the class feeling happy.

Karen's experience with the 'typical' exercise class demonstrates rehabilitation's purpose to improve discrete areas of the physical body, often without consideration for both the utility of the exercise 'out in the world' and the meaningfulness of the process itself. Engaging with disabled people and CDS offers a broader perspective of rehabilitation and can expand what professionals consider to be 'therapeutic' activities. Providing choice in rehabilitation activities and asking for suggestions of the kinds of activities people would like to do, can make therapy more fun and engaging rather than rote, possibly painful, and meaningless. Making activities meaningful and

enjoyable to the participants can humanize what is often a rather de-humanizing experience for people.

Another example of the limits of our professions, in this case with regard to limited understanding of the complexity of people's lives, was encountered by Madeline Burghardt who spent three years working as an OT in Zimbabwe (1990-93), primarily with disabled children and their parents or grandparents. In this work, Madeline often assumed the role of educator – to both explain the corporeal effects of conditions such as cerebral palsy or HIV/AIDS in children to dispel unhelpful myths about the reasons for a child's bodily differences, and to provide some practical instruction to families about how best to support their children with the tasks of daily living in rural situations with limited resources. Although Madeline began the role with the sense that she had something relevant to offer, encounters with people in their daily material lives challenged that certainty. She discovered that families' practical needs, especially regarding how to secure the supports they needed to ensure their child's survival, outweighed any 'tips' she could offer towards relieving the parents' concerns regarding their child's bodymind difference. The usefulness of OT came into question as she began to understand the 'problem' was not people's bodymind difference per se, but their socioeconomic and cultural circumstances and the ways in which these circumstances interacted with understandings of bodymind difference. The task became less about 'helping' people, and more about understanding the effects of poverty, cultural meanings of disability, and politics.

Furthermore, recognizing the 'problem' as something about which she could do little resulted in an unexpected power re-alignment, as her new state of not-knowing positioned her, racial and cultural differences notwithstanding, on a more level playing field with her clients. In retrospect, a more nuanced definition of disability, one that includes consideration of the

distribution of power between disabled and non-disabled people, would have been a helpful tool towards understanding disability as one feature within the complex circumstances of people's lives. Adding even more complexity to the shifting power dynamics between professional and client in this context are processes of colonization, wherein white, Northern health care professionals travel to countries in the Global South to 'help' those 'less fortunate'. How 'help' from the Global North may be complicit in neocolonialism and the often-inappropriate displacement of ideas about disability and non-disability existing in the global South is not addressed in the education of helping professionals (Grech, 2011; Meekosha, 2011; Razak, 2009; 2012). The underlying facets of colonialism often remain hidden behind ideals of 'good intentions' based on Northern notions of medicine, health and disability. These ideals and the framing of trained professionals as knowledge-holders have similarities to Karen's experiences above with Brian and the relationship between professionals and clients more generally. Engaging with disability studies scholarship and the multiple academic disciplines and theoretical frameworks CDS takes up, such as critical race theory, cultural studies, intersectionality, and women and gender studies, allows us to tackle the significance of these power relations and to question how professionals become constituted as expert knowledge-producers and holders, who 'know' the way forward better than clients themselves.

In addition to recognizing the inadequacies of professional knowledge, we also came to realize that such knowledge and the practices that follow may *create* problems or disempower rather than empower the people we intend to support, and may even cause harm. Professional practice is rooted in widely held medicalized understandings of disability which focus on cure, (re)habilitation, and integration of disabled people into 'normal' society. These attempts to normalize establish disability as 'lack' and, ironically, often introduce solutions that hinder access

to the strategies and plans disabled people create for themselves in order to flourish. For example, Madeline, while in Zimbabwe, became aware of her participation in the social and discursive processes that constitute disability as a problem. Situations she was trained to see as problematic, such as a polio survivor using a large stick to get around her rural area with no other assistive device or wheelchair, would not be made better by OT interventions, which, rather, had the potential to make the situation worse.

Another example of how professional imperatives to normalize may be harmful is the focus within speech-language pathology on teaching deaf children to learn to listen and speak⁴. Tracey Edelist, while studying for her Master's degree in Speech-Language Pathology (SLP) (1994-1996), became aware of a tension between Deaf culture and sign language, and SLP's professional imperative to 'habilitate' deaf children to learn spoken language. She found herself needing to reconcile previous knowledge about Deaf culture and sign language (having taken an American Sign Language course during her undergraduate degree), with what she learned in courses like 'Aural Habilitation of Young Children' and 'Speech and the Hearing-Impaired Child'. Enmeshed in a program that taught about hearing, speech, and language 'disorders' and how to 'treat' them, the easiest way to make sense of any discrepancy between speech and sign was to keep them separate: some deaf people learned sign language, others chose to learn spoken language. Years later, the role professional training programs have in perpetuating this discrepancy between sign and speech and in de-validating the importance of sign language for deaf children became clear to her after meeting a teacher of the deaf who was struggling to find ways to teach the high school curriculum to her deaf students. The teacher explained how her students were not fluent in any language, spoken or signed, an unfortunate and complicated outcome of a negative,

⁴ Although not a new idea (Deaf people have been advocating for sign language for over a century), this demonstrates the need for health care professionals to learn about CDS and Deaf Studies scholarship.

medicalized view of deafness, taken up not just by professionals but by parents as well, which prevented some of these students from accessing alternate modes of communication when they were young. Paradoxically, the SLP profession, in attempts to ameliorate the ‘problem’ of the deaf child by prioritizing listening and spoken language, instead created a problem (the hindrance of first language development) for those children who could have benefited from visual modes of communication.

Providing choice and alternative ways to ‘do’ rehabilitation and social work requires helping professions to critically reflect on the professional-client hierarchy and question the normalizing processes that typically frame practice. For example, Tracey came to understand future expectations for spoken language development puts undue pressure on deaf children and their families to work toward that exclusive goal, while limiting both ‘natural’ parent-infant interactions that include gestures and visual communication, and access to sign language services. Learning to listen and speak requires a great deal of ‘work’ on habilitation goals in infancy and early childhood for future expectations of ‘normal’ speech and language (Edelist, 2015; 2016). This focus makes deaf children aware from a very young age their way of understanding the world is ‘wrong’ (Michalko, 2002); that they must conform to spoken language norms if they are to be accepted in hearing society. If, however, professionals were to question these norms, options for acceptable modes of communication and language could be expanded, and the child’s sense of self encouraged.

Ann Fudge Schormans’ work as a new graduate during the time the deinstitutionalization movement in the 1980s was gaining traction provides another example of the complicating potential of ‘helpful’ interventions. In the early years of deinstitutionalization for people labeled/with⁵ intellectual disabilities, she recalls holding fast to the belief (as did many of her co-

⁵ In this paper, we use the term ‘people labeled/with intellectual disabilities’, both in acknowledgment of the critique that people-first language may depoliticize disability and maintain a focus on impairment (Titchkosky, 2001) and in

workers) they were ‘helping’, by rescuing ‘vulnerable’ people from the very real horrors of institutionalization. There was a strong sense of purpose and pride in doing something they believed mattered and made a difference to people’s lives. Efforts (while not always successful) were directed towards facilitating inclusion, working to integrate people into their communities, into a better, more typical or ‘normal’ life.

However, Ann soon realized the process of de-institutionalization and life in the community was still problematic. She became unsettled with the realization that while advocating for inclusion and challenging dominant ideas about the place of people labeled/with intellectual disabilities in the community, she had been trained to simultaneously work to make people with disabilities (more) ‘normal’. For example, during mandatory staff training, Ann recalls being instructed as to what were, and were not, ‘appropriate’ ways for people labeled/with intellectual disabilities to be in the world. Rather than supporting formerly institutionalized people in learning skills for living in the community and exercising their own choices, this felt to her more like an overt policing of their behaviour, their dress, the places they went, the things they did, and the people they should, and should not, do them with. As a pathologizing and hurtful practice, workers were implicated in the violence of telling/reminding people labeled/with intellectual disabilities they were not good enough as they were.

Similarly, while working in child welfare, Ann noted the decision to place a disabled child in care was often framed as what was ‘best for the child’. However, often missing in those

recognition that person-first language is preferred by many self-advocacy groups in Canada. ‘Labeled/with’ language makes plain that labels have been imposed, have harmful consequences, and are ‘not always owned by the individual with regard to whom it is used’ (McClelland et al., 2012, p. 809). The addition of the slash – labeled/with – demonstrates the heterogeneity amongst people identified/identifying with ‘intellectual disability’ (Fudge Schormans, et al., 2019).

conversations was attention to the impact on the children's lives and their sense of self, particularly as they came to understand the reasons they were in care, especially if their non-disabled siblings remained at home. Over time, it became apparent their struggles with internalized ableism were often long-lasting. In this setting as well, she again became uncomfortable with being part of another system that told disabled children they weren't 'good enough'.

Common themes in our coming to CDS

From these accounts, some unifying threads appear. First, the above examples demonstrate how we all experienced the emergence of a disorienting gap between our understanding of the presumed importance of individualized and goal-oriented treatment plans, and our growing awareness of the need for a more expansive approach that included attention to people's most pressing concerns and to their desires. Most difficult was the acknowledgement that our input, even after years of training, might not make any meaningful difference in the lives of those we had been tasked to 'help'. Feeling we had little to offer, while an honest appraisal of the situation, was puzzling, disappointing, and humbling. While the acknowledgement of our own 'lack' in these situations was difficult, we have used it as an opening: an opportunity to recognise clients' knowledge and expertise and to reframe the client-professional relationship as a partnership rather than a hierarchy. Working under the presumed authority granted to those with professional knowledge (Stiker, 1999), we initially assumed the role of more powerful 'helper' in these professional-client interactions, an imbalance that was both an outcome of, and necessary for, the continuation of our professional practice (Foucault, 1994[1973]). Our encounters with people outside the classroom, however, challenged the sanctity of professional knowledge and forced a re-consideration of the taken-for-granted authority with which we had been invested. Karen's encounter with Brian is an

example of how traditional knowledge/power relationships may be inverted (Friere, 1992[1970]) when disabled people's expertise, experience, and desires are centred. We all found that disability studies scholarship provided us with the theoretical foundation to meaningfully engage with this difficult challenge in normative academic and clinical settings.

Another unifying theme is the presumed centrality of the 'problem' of disability, a factor essential to each profession's maintenance and authority, and the deconstruction of which CDS takes as its starting point. As Ann recalls, 'disability' was typically identified as the culprit when disabled children were brought into care. From her experience, workers too often supported the decision to bring disabled children into care as they understood them to be a 'burden' on their families, while the social devaluation of people identified with intellectual disability and the consequent discrimination, lack of supports, and social exclusion experienced by parents of disabled children were not always acknowledged (Fudge Schormans & Sobsey, 2020). In Madeline's case, it was the full-on encounter with a radically different way of life that revealed the limits of traditional definitions of disability. For Tracey, the assumption presented within SLP training and practice that deaf children should unquestionably be made to hear and speak, and that hearing and speaking were at odds with learning sign language, first exposed to her issues within the profession of understanding disability as an individual problem to be remediated. For Karen, it was the realization that the 'problem' of disability could be related to a lack of appropriate equipment and/or assistance by others, and not Brian's 'problem' of learning activities of daily living. Prior to these encounters, we had been instructed to use the language of rehabilitation to define individual differences as problems, with individual goals as the presumed steps in a desired improvement process.

In addition, our experiences demonstrate our lack of preparedness for the political and social complexity of disability. We had all been taught the minutiae of our respective clinical practices, such as the administration of standardized tests, or exercises to improve range of motion, which served primarily to position our clients against normative Northern milestones. Through these encounters, however, we became aware of the isolated and decontextualized nature of standardized tests and exercises and their irrelevance in the face of complex systems of disability supports and regulations, of ableism and social devaluation. Moreover, we became aware of the inevitable limits of the isolated professional-client relationship, and realized the importance of acknowledging contextual and intersectional realities of individuals in order to affect meaningful change.

The early experiences we have described above and the self-reflections they have provoked facilitated the emergence and strengthening of our respective critical perspectives and commitment to disability studies scholarship. Our understandings and perspectives were not new within disability studies research; indeed, disabled activists and scholars have been speaking back to the inequitable power relationships and misrepresentation of disability within medicine and/or rehabilitation for decades (e.g., Asch, 2001; Finkelstein, 1981; Frazee, 2014; Illich, 1974; Zola, 1991). However, as rehabilitation and social work professionals, we were not taught these critical perspectives, and our early practice experiences revealed the extent to which professional training and practice constructed intervention around medicalized ideals that serve to perpetuate problematic constructions of disability and ways of being and doing. In the next section, we discuss some of the literature which takes up critical perspectives of practice in rehabilitation and social work disciplines.

CDS: Current Trends and Uptake in Rehabilitation and Social Work

The rehabilitation literature provides evidence of an increasing yet still somewhat limited emphasis on critical thinking and reflection within the practices of social work and rehabilitation. In PT, OT, SLP, and SW, there is literature that critiques current professional practices, such as evidence-based and standardized practice (Beecham, 2004; Humphries, 2004; Kirmayer, 2012; Martinez-Brawley & Zorita, 2007). Scholars have also critically discussed a number of issues such as patient-centeredness (Cott, 2004; Nicholls, Gibson & Fadyl, 2015; Kvale & Bondevik, 2008; Webb, 2001); anti-oppressive practice (Brown, 2012; Humphries, 2004; Wilson & Beresford, 2000); issues of power and social injustice (Fook, 2003; Hiranandani, 2005; Hocking et al., 2015; Whalley Hammell, 2015); the need for self-reflection in practice (Bauld, 2015; Ng, 2012); the need to assess the appropriateness of social work and rehabilitation practices (Fook, 2003; Kirmayer, 2012; Martinez-Brawley & Zorita, 2007; Wickford & Rosberg, 2012); and rehabilitation services to Indigenous communities (Gerlach, 2018; Peltier, 2011). There has been an impetus to engage with critical theoretical reflection in the disciplines, particularly in physiotherapy (Gibson, Nixon & Nicholls, 2010), where there is also a move towards critically theorizing a conceptual basis for the profession (Cott et al., 1995). Most notably, the global Critical Physiotherapy Network (<https://criticalphysio.net>) advocates for increased engagement in critical thinking and reflection related to teaching, research, and practice, and has developed an online reader that highlights diverse topics and critical approaches in physiotherapy, drawing from critical perspectives including CDS (Gibson, Nicholls, Setchell, & Synne Groven, 2018).

Although not supported by equivalent networks, and not necessarily drawing on CDS, there is literature within OT and SLP that advocates for more equitable practice and critical theorizing. For example, Poost-Foroosh et al. (2014) examined the client-clinician (audiologist) relationship and found clients preferred a shared model of decision-making with clinicians, supporting a move

away from a biomedical model of treatment. This brings to mind our own interactions with disabled people in the early days of our careers in which we desired to honour clients' input in client-professional relationships yet felt constrained due to professional expectations and a limited ability to act within political and administrative bureaucracies. In occupational therapy, Whalley-Hammell has written extensively on the need to bring critical perspectives into practice (e.g., 2013) and others have discussed the theorization of occupation as occupational justice (Block et al., 2016; Wolf et al., 2010; Townsend & Wilcock, 2004). More recently, Farias and Rudman (2019, p. 244) have explored the "possibility of occupation for social transformation" in marginalized communities, positioning OT as a possible contributor to social movements.

The language of social justice is active in social work as well, readily found on the websites of more than half of Canada's accredited schools of social work (Barnoff, Moffatt, Todd & Panitch, 2017). While social work has a long history of concern with the social and with attending to the person-in-environment (Bransford, 2011), the language of social justice established a stronger hold in the profession in the 1990s, and is reflected in radical, feminist, structural, critical, postmodern and post-structural frameworks and practices (Fook, 2003). This turn to critical theorizing has, in only a limited way, extended to disability (Moyle, 2016; Shier, Sinclair & Gault, 2011).

Of particular interest to our group is the way in which our respective disciplines view impairment, define disability, and acknowledge the extent to which the tenets of the profession contribute to disability's ongoing construction as an individual condition requiring expert/professional intervention. For example, there is work in the occupational therapy literature on therapists' reflections of disability as problematic (Bauld, 2015; Thomson, 2015). In social work, ample literature reflecting a charity lens or medicalized, individual pathology definition of disability still exists, alongside which can be found literature questioning these definitions and SW

notions of ‘help’ and ‘expertise’ in the context of disability (e.g., Ballan, 2008; Dunn et al., 2006, 2008; Hiranandani, 2005; Shier et al., 2011), as well as critical reflection on SW’s complicity in disablement (e.g., Fudge Schormans, 2015; Gibson, 2015; Kelly & Chapman, 2015; Voronka et al., 2014). In the speech language pathology literature, different models of disability and their applicability and importance to reflective SLP practice have been theorized (e.g., Donaldson, Chabon, Lee-Wilkerson & Kapantzoglou, 2017; Eadie, 2001; Jordan & Bryan, 2001) and the social model of disability has been promoted as a philosophy that can inform therapy (e.g., Pound, 2011; Byng & Felson Duchan, 2005). For example, in the UK, Byng and Felson Duchan (2005) illustrate how the implementation of social model principles into practice with people living with aphasia can work to equalize the client-practitioner relationship and allow clients to have choice of and control over their therapeutic activities to create engaging and meaningful experiences. They also suggest social model principles can inform a number of different treatment practices, including “impairment-focused therapies,” if the SLP’s attitudes and beliefs align with a social model philosophy of building equitable client-practitioner relationships (Byng & Felson Duchan, 2005, p. 918).

There has also been examination of the relationship between disability and colonialism in rehabilitation through a postcolonial lens (Frank et al., 2008). For example, Nixon et al. (2015) used a critical, postcolonial perspective to explore the varied meanings of disability and rehabilitation in Canada and Cameroon, indicating the importance of a collective understanding across the Global North and South, rather than a narrow focus on North American rehabilitation principles. Indeed, the rehabilitation professions, social work, as well as the field of disability studies itself, would do well to incorporate broader definitions of disability and consider the

intersectionality of disability experiences, found in the work of Indigenous and BIPOC scholars (e.g., Bell, 2011; El-Lahib, 2017; Erevelles, 2011; Million, 2014).

While the literature indicates some critical considerations of disability and professional practice, evidence remains of the ongoing reliance on individualized approaches, such as we experienced in practice. Farias and Rudman (2019, p. 244), for example, state that despite interest in the use of OT for social justice movements in some settings, participatory and community-based work continues to exist “at the margins of the profession”. Within SLP, Yu and Epstein’s (2011) study of student practitioner attitudes about disability before and after learning about the social model, suggested a change of orientation towards a social model philosophy after learning about it. However, after they conducted a case study analysis, more students took on a mixed orientation (both medical and social model understandings), pointing to a tension implementing the social model in practice (Yu & Epstein, 2011). In addition, while this literature suggests a movement towards an increased commitment to critical practice, these efforts appear siloed – there has been little discussion of the importance of an interdisciplinary critical disability studies approach. While the reasons for this are not fully understood, this could stem in part from each profession’s historical need to claim sufficient legitimacy within biomedicine as a whole and the resultant protection of each profession’s particular skill set (e.g., Eaton & Regan, 2015; Miles-Tapping, 1989; Clark, 2010; Lall, Klein & Brown, 2003). When interdisciplinary approaches *are* prioritized, as is the case with interdisciplinary team arrangements, critical and politicized interpretations of disability are not always apparent and the client’s perspective may not be included (McLellan & Ward, 2002).

Although the literature reviewed above provides some evidence of critical and nuanced approaches within each profession, the need for a more rigorous uptake of critical perspectives in

rehabilitation and social work professions is perhaps best demonstrated by the ongoing oppression of disabled people. Despite decades of rehabilitation and social work practice (indeed, most professions are now entering their second century), disabled people continue to experience oppression in all areas of society – physical, occupational, communicative, and social – casting doubt on the efficacy and value of these forms of intervention, and leading some CDS scholars to call for abandoning rehabilitation practices altogether. Stiker (1999, p. 187), in his seminal writing of the history of disability, describes rehabilitation as a “brokered contract” between the “aberrant” disabled subject and the remainder of society, and suggests rehabilitation’s long-term goal of assimilation runs counter to a realistic and vibrant social fabric. Others (e.g., Dauphinee, 2017) have provided personal accounts of the need to seriously reconsider the efficacy and value of a rehabilitation approach. Considering the firm place of rehabilitation in society, we believe a more rigorous uptake of critical curricula in the academy may be a good first step to address ableist practices. In the following and final section, we suggest ways in which critical analyses of disability can be more rigorously introduced into the professional curriculum.

CDS Perspectives in Professional Academic Spaces: Obstacles and Tensions

Despite indications of a shift towards enhanced critical awareness of assumptions regarding disability and professional intervention, and a growing demand by students for content, dedicated courses and critical disability concentrations (Laws, Parrish & Egan, 2010), the introduction of such frameworks remains contentious within the academy (Barnes, 2014; Block, 2004; Dunn et al., 2006, 2008; Hiranandani, 2005; Imrie, 2014; Kafer, 2003). We first trace possible explanations for the reluctance to adopt more critical approaches, before discussing ways to introduce these approaches into professional training.

First, scholars have identified the co-constitutive nature of the relationship between people identified as ‘needing’ professional expertise and the explosion of professions designed to provide it, while people marked as ‘vulnerable’ come to be seen as dependent on those services. Equally notable is the dependence of the helping professions on their ‘at risk’ clients (Butler, Gambetti & Sabsay, 2016; Oliver, 1990; Illich 1974). Illich et al. (1977, p. 11) identified the mid-twentieth century as “The Age of Disabling Professions, an age when people had “problems”, experts had “solutions” and scientists measured imponderables such as “abilities” and “needs””, a description that may apply to the current context as well. For example, social work continues to be involved in policies and practices rooted in eugenic ideas such as prenatal screening (Gibson, 2015).

Second, practitioners who adopt critical perspectives may face resistance from those in the field who continue to abide by more traditional models of intervention. These include practitioners who supervise students in field placements. Students in rehabilitation and social work programs are required to complete field placements, and with ever increasing enrollments, students may be placed into settings that may or may not have clinicians who embrace more critical approaches or practices. Thus, even though students may have learned critical approaches and wish to use them in practice, they may not have the opportunity to do so. Instead, they may have to practice in accordance with their clinical instructor’s traditional approach. Yu and Epstein’s (2011) finding that students who had embraced a social model philosophy but again took up a medical perspective after encountering a case study, points to the need for practicum supervisors who can support students in applying more critical approaches to practice.

In addition, academic programs are obligated to teach students particular ‘competencies’ to ensure adherence to each profession’s code and standards of practice upon graduation. While these accreditation regulations are practical and intended to serve to protect the public from harm, they

do not allow for much critical thought. Karen's encounter with Brian exemplifies how this can play out during practicum: practicum supervisors may simulate real-life events to create learning opportunities for their students, even when the tasks being practiced are of little use to the client. The exploitation of clients' time and energy this entails, a partial reflection of the power differentials embedded in these relationships, generally goes unnoticed and is considered 'reasonable' within the context of these criteria-based training programs. Given that each of these professions has worked diligently to achieve the status and recognition afforded by their respective professional regulatory colleges, challenging the standards set by the colleges by introducing more nuanced and politically inspired forms of practice could jeopardize the reputation of both individual practitioners and academic programs. Academic programs may also risk losing accreditation if such practices run counter to regulatory expectations.

Further, academic environments, despite traditionally being understood as sites for argument and proliferation of ideas, are notoriously slow at introducing change. In addition to procedural obstacles such as lengthy review and approval processes, current demands for curricula that satisfy market-oriented educational goals, as opposed to critical pedagogy (Clegg, 2010), can make the introduction of alternate curricula a daunting and time-consuming exercise, one in which not all academics are willing or able to engage (Mountz et al., 2015). The already crowded and tightly controlled professional curricula means greater inclusion of CDS will require a strong and concerted push (Laws et al., 2010; Moyle, 2016). At the level of the academy, shifting foundational attitudes, beliefs, and values regarding disability, as well as disciplinary contexts and cultures that are necessary for change to occur, will take time (Barnes, 2014; Imrie, 2014; Yoshida, Self, & Willis, 2016).

At present, two of the authors work within professional programs and have been able to develop CDS content and courses within these programs. Karen has developed and taught CDS content within University of Toronto's Physical Therapy program for the past 30 years in partnership with disabled scholars, disability communities, and other disability positive allies (see Yoshida, Self, & Willis, 2016; Yoshida, Self, Willis, & Rose, 2017). Despite the success of the CDS content, she has had to remain vigilant to ensure the presence of CDS within this program. Ann does the same at the School of Social Work at McMaster University, developing and teaching CDS content in courses at the undergraduate and graduate levels. There are other examples of CDS concentrations, specialties, and components within social work education (e.g., Carter, Hanes & MacDonald, 2012; Ogden, McAllister & Neely-Brown, 2017), and in Occupational Therapy (Block, 2004; Block et al., 2016). While examples of CDS content in various programs are promising, they must become required core content, developed in partnership with diverse communities. For this to happen, professional and academic accreditation standards need to explicitly support CDS content at programmatic levels.

Conclusion

Despite the promising forays into CDS by some scholars and practitioners within rehabilitation and social work, ongoing concerns remain. Although the professions discussed here share a commitment to improving the lives of disabled people, for that goal to be realized, the work of challenging traditional understandings of 'impairment' and 'disability', as well as the approaches and models that guide rehabilitation and social work practice within professional programs must continue. Our experiences over the last few decades suggest if the desires of disabled people are to be prioritized, then assessments and interventions, and indeed, professional knowledge, must

take the multiple and intersecting factors affecting people's lives into account. Within each discipline, there is the need to incorporate an understanding of disability (along with race, gender, class, and other social identities) as a political and intersectional issue into curricula and practice. CDS supports such an understanding, while foregrounding disabled people's lived experiences. As such, bringing CDS into rehabilitation and social work practice and learning would centre the wants and needs of disabled people, from their own perspectives and social positions, and would thus challenge professional boundaries and practice.

One way forward is to continue to build connections among scholars and activists from critical disability studies, communities of people identified/identifying with bodymind difference, and rehabilitation/social work. Developing collectives is key to addressing the tensions of teaching CDS in allied health care education, as they may assist allied health professions and professional academic programs to take up critical perspectives in relation to disability and intersectional experiences. Our reflections encourage us to advocate for programs that inspire students, academics, and placement supervisors to question and challenge professional assumptions about disability, and that allow for the critique of traditional methods of assessment, treatment, and goal setting. In particular, we advocate for practicum-based programs in which students are exposed to people's lived experiences of disability in real social environments, and most importantly, which allow disabled people to teach students what is relevant and important to them.

Acknowledgement

The experiences featured in this article were first presented as a panel entitled *Teaching Disability Studies in Non-Disability Studies Academic Spaces* at the 2016 Canadian Disability Studies Association conference in Calgary, Alberta. The session was well-received; many in the audience,

having in the past been ‘receivers’ of ‘therapy’, told us they felt affirmed by our sharing the disquiet we had all encountered in our professional lives, our ‘shift’ towards more critical scholarship, and our challenge to rehabilitation and social work, thus setting up an important location of solidarity. We are grateful these disabled scholars encouraged us to tell our stories to a broader CDS community. While this work has for each of us been isolating at times, our stories show the possibilities and the collectivity we are hoping to foster and grow. We extend an invitation to others to join us in continuing to move critical disability studies into non-critical disability studies academic spaces.

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