My Occupational Therapy Education as a Person With Visual and Physical Disabilities

As occupational therapists, we daily interact with and educate clients with disabilities, but what happens when a student with multiple disabilities trains as an occupational therapist?

Although access to educational programs is legally mandated, occupational therapy students and professionals with disabilities still must deal with the more subtle cultural aspects of living with disabling conditions in society in general and of practicing within an allied health field.

Congenitally disabled with cerebral palsy, I received a master's degree in library science and worked for a number of years as an academic librarian before losing a substantial amount of vision secondary to delayed-onset retinopathy of prematurity. In my mid-thirties, I entered the occupational therapy certificate program at Thomas Jefferson University in Philadelphia. My decision to enter the field was based both on my personal preference of beginning a new career in a helping profession and on the availability of jobs in the occupational therapy field. This paper, written as I completed my final affiliation, reflects on my own work and progress as well as on the reactions of faculty, students, clinicians, and clients to my presence in the classroom and the clinic.

By recounting personal experiences and drawing upon the literature on disability and culture, I will show how it is not only possible but also necessary for otherwise qualified interested students with disabilities to gain access to occupational therapy programs and to enter the profession. I will address simple, practical solutions to expected and unexpected educational problems. In addition, I will explore attitudinal and cultural barriers.

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Self-Image

Before discussing my educational experiences, I want to emphasize that I do not think I did anything especially unusual or, as has been suggested to me by well-intentioned but uninformed people, extraordinary or inspiring by choosing occupational therapy as a career and subsequently completing an accelerated program of study and clinical work. Research into life histories of persons with congenital disabilities supports my assertion that we view ourselves as able individuals who happen to be disabled by physical conditions and a cultural stigma with which we must grapple (Frank, 1984; Zola, 1982).

Our profession has its roots in such values as individual choice and human potential, and it has striven to enable clients to reach or regain functional status and assume roles found to be of intrinsic value (Bruce & Christiansen, 1988). Therefore, by occupational therapy standards, I did nothing out of the ordinary in pursuing a goal to fulfill my potential. What was unusual in my particular case was the manner in which I undertook and completed the course work and the vantage point I assumed by combining my experiences as a woman with congenital and acquired disabilities with my role as a health service professional.

Educational Considerations

When I entered the certificate program at Thomas Jefferson, I encountered an educational atmosphere that was very different from the atmosphere I had encountered during my previous undergraduate and graduate work, most of which had been based in the humanities and in library science. With the exception of the prerequisite occupational therapy courses I had taken at a local community college, all my previous scholastic work I had completed in my early twenties in the customary manner.

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with no need for adaptations. However, when I returned to school with impaired vision and the effects of on-going degenerative joint disease, I had to anticipate and construct my own method of completing the course work, which was of a scientific and theoretical nature. In a predmission interview with the chair of the department, I stated that I anticipated needing four specific accommodations: (a) an extended reading period for examinations because Thomas Jefferson does not have a center for disabled students or provide reading services, (b) an alternative method to complete anatomy and neuroanatomy laboratories; (c) fieldwork sites accessible by public transportation because I no longer drove; and (d) permission to tape classroom lectures for later written transcription. The department chair and later, various faculty members, did not view these accommodations as giving me an unfair advantage over able-bodied students. Indeed, the accommodations were minimal and within my legal rights under federal rehabilitation legislation. The faculty proved to be supportive beyond providing the accommodations initially agreed on; one instructor, who gave open-book examinations, refused to allow me to take her examinations, grading me instead on class participation and a series of special projects and papers incorporating course material. By making my needs known and solving problems in collaboration with faculty members, I was able to complete all the required course work with a few minor exceptions. For example, I was unable to perform maximum-assisting transfers alone or cut wood for crafts projects using a bandsaw. However, I have not found these exclusions to be of major importance in my clinical work.

My experience with the Thomas Jefferson faculty is typical of the experience that many students with disabilities have. Although disabled students attending institutions that provide centers for them seem to have an advantage over disabled students enrolled in schools without such centers, research has shown that much depends on the faculty. Instructors are more likely to use accessible methods if they have a hand in developing them, and, working from a team approach, they are best able to adapt programs as necessary for students with disabilities ("Focus on Faculty," 1987). Students attending larger universities with limited staff interaction and students who have more difficulty ascertaining or asserting their needs have often benefited from a mentorship ("Focus on Faculty"). Additionally, faculty members who have taught qualified students with disabilities have been found to have the most positive attitudes toward the group and to be willing to remain flexible without lowering standards ("Focus on Faculty"). From my own experience and from comments made by faculty members throughout my time at Thomas Jefferson, I have found faculty members, for the most part, not only willing to be flexible and adaptive (as occupational therapists should be), but also willing to consider another's point of view, incorporating my experience and suggestions into the classroom when appropriate.

Students' Response

I found faculty members to be flexible and supportive; however, this was not always the case with my fellow students. Like other students with disabilities who have entered health professions (Hartman & Hartman, 1981; Roush, 1986), I was aware that I would be an anomaly—a health professional with a permanent, chronic disability. Nonetheless, I entered the program naively assuming that occupational therapy students, as opposed to the average college student, would be more aware of and attuned to the needs of persons with disabilities. Although I admittedly made a few very good friends and developed a network of potential colleagues at Thomas Jefferson, I also encountered covert prejudice and, in some cases, overt "ableism." (The term "ableism" was coined by disability rights activists; it refers to an attitude that places an exaggerated value on able-bodiedness.) Perhaps nowhere was this attitude more apparent than in my neuroanatomy course. To accommodate my low vision and spatial awareness difficulties, the instructor offered me 15 minutes of private instruction at the end of each 3-hour laboratory. Most students finished their laboratory work well before the allotted time, and there were laboratory assistants to work with any remaining students; therefore, my time with the instructor posed no hardship on any other student. I took laboratory examinations with the instructor, who was willing to verbally explain any visual clues I was unable to see. To work effectively with this instructor, I was always prepared and never expected or received any breaks. Nevertheless, a few students complained about my receiving an unfair advantage in the course. Having spent approximately 6 hours transcribing each lecture tape and having to accommodate both visual and right-hemisphere deficits while dealing with negative reactions from classmates, I was unaware of having any advantage.

Literature Review

After the incident in my neuroanatomy class, I reconsidered my initial assumptions that all occupational therapy students and personnel were aware of disability issues—issues that I, by virtue of my societal status as a woman with disabilities, had been aware of throughout my life (Ekler, 1983; Fite & Asch, 1981). In a literature search I found some articles published in the American Journal of Occupational Therapy in the early 1970s on the psychological effects of disability (Simon, 1971; Vargo, 1976) as well as one program's attempt at introducing students to what was termed "the lifestyle of the physically disabled" (Marmo, 1975). Articles published in the American Journal of Occupational Therapy in the early 1980s began to focus more clearly on this issue, but the topic was approached either from the point of view of providing an occupational therapy planned intervention program to service-disabled college students (Burnett & Yerxa, 1980) or as a study of attitudes toward children with disabilities (Shortridge, 1982). In short, there was an attempt to raise consciousness, but this attempt was generally based on the assumption that there was a very clear, cultural delineation between therapists and "the disabled," most of whom were...
viewed as one amorphous group, usually consisting of either children or elderly persons. Not until the mid- to late 1980s, approximately 10 years after the rise of disability rights groups, did occupational therapy literature begin to address the cultural aspects of disability (Pedretti, 1985), with special emphasis on attitudinal barriers (Bruce & Christiansen, 1988; Montagu, 1985). Additional research on reactions to disabled students yielded only attitudes toward children and younger students (Horne, 1985), with no indication of peer attitudes to college students. Considering that 4% to 6% of incoming 1st-year college students are disabled (“Focus on Faculty,” 1987), more research remains to be conducted on peer reactions. Such research would be especially beneficial to the occupational therapy profession because it would allow us to identify and address areas of concern within a structured setting rather than running the risk of allowing unacknowledged or acknowledged “ableism” to interfere with the treatment of our clients.

Clinical Considerations

Beyond the academic aspects of my training, my clinical experiences as a student afforded me several opportunities to measure clinicians’ and clients’ attitudes toward disability. With one exception, clinicians did not treat me differently than other fieldwork students except for a few initial queries as to how I managed specific tasks. For my final physical dysfunction affiliation, I interviewed with the assistant head of an occupational therapy department in a large urban hospital. After explaining that I would need assistance for any maximum-assist transfer and that I would possibly use a low-vision lens to write notes, I was told that these concerns would pose no problems because some of the other therapists also used help for heavy transfers. The interview was cordial and positive. Two weeks later, the department head, who never met me, cancelled my affiliation on grounds of disability. Although she was within her rights as a supervisor, I think the incident raises some interesting ethical questions. Able-bodied people often feel uneasy in the presence of those of us who have disabilities. Perhaps, as has been suggested, we remind able-bodied persons of their own vulnerability to disease, disability, and the randomness of fate (Murphy, 1987). Able-bodied health care professionals have been found to have attitudes ranging from ambivalence to hostility toward disabled colleagues (Koush, 1986). Disabled women, in particular, have met with attitudinal barriers when entering professions (Falva, 1985). Even in the profession of occupational therapy, such an attitude may exist because of an ingrained societal attitude that views disability as a stigma (Goffman, 1963). If we truly believe in rehabilitating clients, we must acknowledge and challenge these attitudes on a personal and professional level.

If I have used my disabilities to my advantage, it has been in my interaction with and treatment of clients. Virtually all of my clinical supervisors have commented on my ability to analyze and grade activities effectively for various client populations and to provide strategies for success-oriented treatment beyond the skills of a beginning therapist. Disability has never been a negative issue in my interactions with clients. Many of my clinical supervisors chose to use the word motivate to describe what I did for my clients. I, however, prefer to think I used myself therapeutically, offering an example of someone working effectively with disabilities, without emphasizing the conditions.

Challenges for the Future

Perhaps the two most critical areas that we as occupational therapists need to address and change are those of attitude and language. Language is a powerful tool; its power is especially menacing in its subtle manipulation of attitude toward disability (Longmore, 1985; Zola, 1981). To speak of the disabled is an example of this power; the term dehumanizes those of us who have disabilities, stripping us of our individual identities. Negative stereotypes of persons with disabilities abound in the American culture (Klobas, 1985); language can reinforce these stereotypes. If we speak of the disabled child, we define persons in terms of their disabilities. A more holistic definition would use a neutral word, like “a person” first and then follow it by a modifier indicating the disabling condition, always emphasizing the positive, for example, the woman who is blind or partially sighted, the child with a learning disability. If we ask a client to perform a task with either his good or his bad leg, we are exposing our own prejudice as well as imposing a negative self-image on the client. As occupational therapists, we must use positive, realistic language. Within our profession, we must also define and precisely use the terms disability and handicap (Bruce & Christiansen, 1988).

If we are to remain true to our professional calling, we must look beyond physical and environmental adaptations: Culture is the ultimate environment with which we are faced (Barris, Kiethofener, Levine, & Neville, 1985). To live with a disability in this culture is to face major attitudinal barriers (Weiner, 1986). If we are to treat clients effectively, we must acknowledge and challenge these barriers in our educational programs. Several methods exist to accomplish this task. The most popular has been simulating a disability. Although simulation has its limitations, it is a beginning. We should use simulation exercises, ideally planned with input from or taught by people with disabilities, as well as interaction with people with various disabilities, in the classroom. Speakers from local disability rights groups, independent living centers, wheelchair athletic groups, and support groups could also help raise consciousness, as could the incorporation of classes dealing with disability and culture into the curriculum.

Conclusion

We need to ensure that qualified and interested students with disabilities have actual access (the right to such access is not enough) to occupational therapy education and employment. We need to work together with such students to help them reach their full potential. As professionals with or without disabilities, we need to explore more fully the cultural impact.
of disability within our field and society at large. Attitudinal barriers may be difficult to remove; but before they can be removed, they need to be acknowledged and researched. By becoming involved in these activities, occupational therapists and their clients can only benefit.

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References


