

## Yale College Education Studies Program

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Senior Capstone Projects

Student Research

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# The Disabling Effects of Society: Approaching the Education of Autistic Students through a Social Model of Disability

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**Abstract:** This paper discusses the strengths and weaknesses of the dominant educational paradigm used in the education of autistic students: the deficit-based medical model. Drawing from primary sources, legislation, student records, and current special education pedagogy, the paper assesses how and why the dominant approach to education fails autistic students—academically, socially, and emotionally. I advocate for the education of autistic students to be approached through a social model of disability—one that recognizes and supports autism spectrum disorder (ASD) as a natural human variation. Rather than assuming that disability is inherent to a person, the social model adjusts students’ physical, cognitive, and emotional environment to better suit their needs. To begin, I compare and contrast the medical model and social model of disability to show what can and should be done to better educate autistic children, including how classrooms can enact the social model. Scholars who have written about the social model of disability focus on defending it as a viable theory or concept to be adopted by society, but they have failed to convince stakeholders to implement the model as a practical tool to change education and improve the lives of autistic students. Drawing from literature on the social model of disability, disability theory, queer theory, and critical race theory, and based on consulting with current school administrators and special education teachers, I conclude with preliminary recommendations on how elementary school teachers can implement the social model of disability in the classroom. The tools and resources provided in this paper are an essential step toward a paradigm shift in education for autistic students.

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## Introduction

This past summer, I conducted research on group therapy's effect on the social-communicative skills and quality of life of autistic adults. The goal of group therapy for autistic adults is to provide a behavioral intervention that is efficient and cost-effective and offers a social support system to increase an individual's independence and quality of life (Kerns et al., 2016). My future career goals include implementing these interventions for autistic adults. As I sat in on these weekly group therapy sessions over the summer, I wondered why many of the participants felt that they have been failed by their educational experience. Participants shared how they felt ostracized by teachers and peers. Further, teachers and administrations would constantly tell participants that something was wrong with them and how they needed to change, instead of focusing on their strengths and adjusting their environment to fit their needs. Not all autistic students feel negatively about their education. For example, one participant felt that their school, a specialized private school for autistic students with tuition costs of ~\$60,000 a year, did a great job of supporting and providing them with resources. Few schools like that exist and those that do exist are widely inaccessible due to their prohibitive costs.

The primary goal of education for autistic students aligns with the goals that education sets forth for all students. The goals include developing skills that increase independence and amassing knowledge that will enable students to have productive, meaningful lives. What can, and in some cases should differ, is the educational means to meet the goals. The current approach to special education, especially education for autistic individuals, too often ignores the need to alter traditional means of instruction. Inappropriately, schools try to "fix" deficits and mold students into being as "normal" as possible. That approach follows the medical model of disability: focusing

on an individual's deficits and claiming the disability is a part of the individual that can and should be changed (Goering, 2015).

The medical model of disability, the dominant educational approach for autistic students at the majority of public schools, does not follow the progressive pedagogy provided by most specialized private schools for autistic students described above. But what if schools changed the paradigm through which they approached the education of autistic students to better suit their needs? What if all schools enacted pedagogy focused on increasing students' likelihood of having a higher quality of life? A new approach that would not require such a large amount of medical interventions that impose high emotional, physical, and financial costs and, as a result, diminish the wellbeing of autistic students and their families. This paper explores how implementing ideas from a new model of disability – the social model of disability – would better support autistic students in the classroom (see Table 1). That way, all autistic students, regardless of resources, could benefit from a positive educational experience.

**Table 1** *Medical vs Social Model in Schools*

<b>Medical Model</b>	<b>Social Model</b>
Child is Faulty	Child is Valued
Diagnosis	Strengths and Needs Defined by Self and Others
Labeling	Identify Barriers and Develop Solutions
Impairment Becomes Focus of Attention	Outcome Based Program Designed
Assessment, Monitoring, Programs of Therapy Imposed	Resources are Made Available to Ordinary Services
Segregation and Alternative Services	Training for Parents and Professionals
Ordinary Needs Put on Hold	Relationships Nurtured
Reentry if “Normal Enough” OR Permanent Exclusion	Diversity Welcomed, Child is Included
Society remains unchanged	Society Evolves

*Note.* Reprinted from Understanding the Social Model of Disability: the ‘Medical Model’ Versus the ‘Social Model’, by UK Disability History Month, retrieved from <https://ukdhm.org/what-is-ukdhm/the-social-model/>, Copyright 2020 by World of Inclusion Ltd. Table 1 highlights the basic ideology of each models within educational settings.

A social model approach focuses on the characteristics of an autistic student’s social context and sees their disability as the result of a “poor fit between the (physical, cognitive, or emotional) characteristics of that given individual and the characteristics of their social context” (den Houting, 2019; Goering, 2015). Instead of framing autism spectrum disorder (ASD) as a problem that resides inside a particular person and needs to be fixed, as the medical model of disability does, a social model identifies and addresses external environmental, attitudinal, and organizational factors in society (e.g. systemic barriers, derogatory attitudes, and social exclusion) that make it increasingly difficult for disabled individuals to function in society.

In addition to a scientific framing about the negative effects of the medical model of disability on autistic students, this paper addresses ontological questions about what it means to be considered an outcast in the world. By interweaving similarities in the ideologies of queer theory,

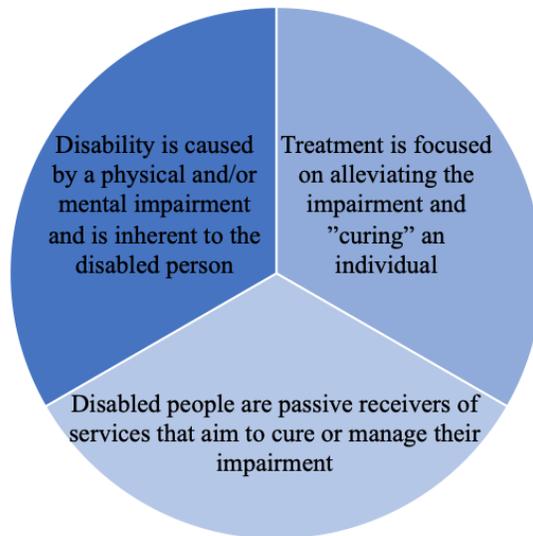
critical race theory, and disability theory, this paper addresses how queerness, race, and disability – each themselves an overarching term for a range of subjects and identities – are connected through normativity. And specifically, how able-bodiedness plays as big a role in the dangers of societal norms as heteronormativity and white supremacy.

The social model of disability centers around neurodiversity – the notion that neurological differences should be recognized and respected as any other human variation (Jaarsma & Welin, 2012). Humans vary in relation to every characteristic. Some of the most mainstream variations include eye color, height, blood type, and hair color. The social model promotes ASD be accepted as any of the natural variations listed above. Our education system emphasizes an individual's deficits rather than adjusting one's environment to fit their needs and abilities. The transition to a social model dominated approach would shift schools from looking at ASD as an impairment (actual attributes or lack of attributes that affect a person) to a disability (restrictions caused by society when it does not give equivalent attention and accommodation to the needs of individuals with impairments). In doing so, the social model would enable schools to better meet the needs and abilities of autistic individuals (see Figure 1).

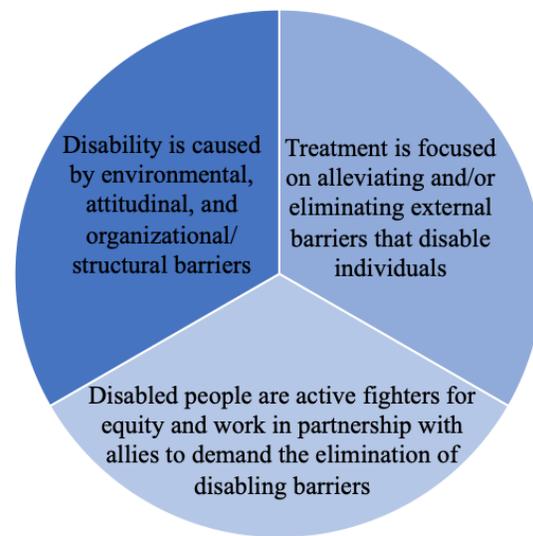
**Figure 1**

*Key Factors in the Medical Model and the Social Model of Disability*

### **The Medical Model of Disability**



### **The Social Model of Disability**



To convince stakeholders in autistic education that the social model of disability would better support autistic students, I address the following research questions:

1. What are the differences between the medical approach and the social model of disability? What are the strengths and weaknesses of each model?
2. In what ways do the weaknesses of the medical model approach to education fail autistic students academically, socially, and emotionally? How do aspects of the social model address the faults of the medical model and still provide an academically effective approach?

These questions provide the critical framing for taking up the process of implementing the social model of disability within schools. A successful implementation would require the social model to be implemented across multiple domains: classroom-wide, school-wide, district-wide, state-wide, and nationally. With awareness about the other levels of intervention that would need

to be addressed before a full transition to the social model of disability, this paper also answers a third research question:

3. What steps would elementary school teachers need to take to enact a social model of disability in their classroom?

To answer this critical question, I offer practical suggestions for how elementary school teachers could implement the social model of disability in their classrooms. I provide preliminary suggestions for implementing this model in the elementary classroom: 1) to ensure early intervention in children's schooling, 2) to take advantage of the close relationship between teachers and students and families, and 3) to make use of the quick, cost-effective, and efficient changes that the elementary school classroom presents. Structural change is always slow, but improving the education of autistic individuals is time sensitive. Elementary school classrooms offer an avenue through which these issues can be quickly addressed, thereby minimizing further damage to students. By beginning in the classroom, the social model could become adopted and normalized among teachers. This would lower the barriers of change to bigger interventions at the school, district, state, and national level.

While my paper dives into implementation at the classroom level, teachers do not exist in isolation and often have constraints imposed upon them which they must comply with. The context and/or climate of a school and its leadership can prevent even the best educators from successful implementation. Additionally, teachers who attempt to make a change at a classroom level are often working in a vacuum, a challenging and lonely part of the profession. Implementation at a classroom level is a challenging task, but starting at the teacher level enables a larger, more

efficient impact on an individual basis. Teachers need to be able to improve the education of their students. It's even more important that these individual teachers are recognized and supported by upper leadership who have more say and more resources. That will provide for a larger difference than one teacher trying to implement this model alone.

### **Important Note**

I am a neurotypical person writing about the experiences of autistic individuals – experiences that I will inherently never fully be able to understand and I must be cautious in representing the preferences of a community that I am not a part of. When beginning this paper, I struggled in determining which terminology – *person-first* or *identity-first* – to use. *Person-first* language refers to the person before a diagnosis: “a person with ASD.” *Identity-first* language refers to someone with a diagnosis as a descriptor: “an autistic person.” Many of the autistic individuals I've had the opportunity to work with prefer person-first language because they think the word “autistic” is still stigmatized. Nonetheless, identity-first language is becoming increasingly popular among autistic advocates in the community (Brown, 2011; Halmari, 2011; Kenny et al., 2016).

After some research, I decided I would use identity-first terminology in this paper. I say “an autistic student” instead of person-first language like “a student with ASD.” Identity-first language aligns with the social model's perspective that ASD is a normal variation that should be recognized and valued. Alongside the push for neurodiversity, many autistic people have begun advocating for the use of identity-first language, rather than person-first language. Advocates for identity-first language dislike person-first language because it suggests that their ASD and personhood are somehow separate (Robison, 2019).

Additionally, person-first language makes some people feel that their ASD is something to be ashamed about or that ASD is a disease that needs to be cured (Crocker & Smith, 2019). That doesn't mean that those who use identity-first language see themselves as any less human, but rather that their ASD fundamentally influences who they are like other aspects of a person, such as race, gender identity, and sexual orientation (Robison, 2019). Conversely, some advocates argue against identity-first language because "autistic person" feels to them like it still has a negative connotation in our society (Brown, 2011). The issue is controversial, with many advocates on both sides of the debate (Callahan, 2018).

Embracing a neurodiversity perspective of ASD means one recognizes ASD as a naturally occurring variation that should be accepted and supported. Through my research, I have learned more about the neurodiversity movement and the importance of identity-first language in the ASD community. Still, when speaking with autistic individuals who prefer person-first language, I strive to respect their preferences and alter my language.

### **Methodology**

The existing research on the education of autistic students focuses mainly on the history of special education, current educational services provided, student peer influence, transition programs, and educational interventions (Nee, 2013; Simpson et al., 2011). Scholars who have written about the social model of disability focus on defending it as a viable theory or concept to be adopted by society. They have failed to move past this defensive posture to use the model as a practical tool to implement changes in education to improve the lives of autistic students. To answer my research questions, I first address the strengths and weaknesses of both the medical model of disability and the social model of disability. My research on the education of autistic

students and independence and outcome records has shed light on how and why the current approach to education fails autistic students.

After analyzing both model paradigms and their effects on the education and wellbeing of autistic students, I discuss the implementation of the social model of disability. Research on the social model of disability is limited since the neurodiversity movement is only recently gaining traction from neurotypical stakeholders such as caregivers, doctors, psychologists, and educators (den Houting, 2019). The social model of disability stems from disability theory, which in turn is influenced by queer theory and critical race theory (Annamma et al., 2018; den Houting, 2019; Sherry, 2004). To inform my social model implementation ideas, I aim to grasp the research intersections between these four disciplines: the social model of disability, disability theory, queer theory, and critical race theory.

In addition to reviewing the four fields, I consulted with special education educators and administrators for background information. In relation to disability theory, queer theory, and critical race theory, I discuss the dangers of normative thinking and consider research that explains the benefit of the social model of disability. Through this research and application, I then compiled preliminary suggestions for elementary school teachers to enact the social model of disability in their classrooms.

### **Background on ASD**

ASD is defined as a social learning disorder that affects an individual throughout their lifetime (Volkmar et al., 2004). A psychiatrist named Leo Kanner first publicly identified autism in 1943. Kanner diagnosed his patients with “early infantile autism” and described the children as coming “into the world with an innate inability to form the usual, biologically provided contact with people” (Harris, 2018). Today, autistic people are diagnosed when they are thought to have

deficits in social communication skills—such as difficulty starting conversations and maintaining eye contact—and have distinctive social functioning, including restricted interests and repetitive behaviors (American Psychiatric Association, 2013; Volkmar et al., 2004).

Previously thought to be rare, ASD now follows intellectual disability and cerebral palsy as the third most commonly diagnosed developmental disability in America (Centers for Disease Control and Prevention, 2020). Some of the first autism prevalence studies were conducted in the late 1960's and early 1970's and estimated that two to four children were diagnosed with autism per 10,000 children (Treffert, 1970). By 2002, autism was on average being diagnosed with a prevalence of 6.7 or one in every 150 children. According to the 2020 estimates from the Centers for Disease Control and Prevention (CDC), ASD affects about one in 54 children in the U.S. by the age of eight (Maenner et al., 2020). The cause of the increase in the diagnosis of ASD is unknown. Some scholars attribute it to “(1) the relatively recent (1992) classification of ASD as a disability requiring special education and a concomitant shifting of diagnoses from other disabilities, (2) better tools for diagnosing ASD, and (3) changes in classification patterns” (Spigel, 2006).

## **Special Education and ASD**

### **Special Education History**

Special education has had a brief but productive history in America. Educational opportunities for individuals with disabilities began to increase when education became compulsory in the early 20th century (Yell et al., 1998). Prior to 1975, there was no legal requirement for states to provide educational services to children with intellectual or developmental disabilities (VanBergeijk et al., 2008). A school district could, and often did, refuse to educate a child with disabilities, citing a lack of funding or a lack of appropriate educational

services (Yell et al., 1998). Although opportunities to be admitted into the educational system increased for disabled students in the late 20<sup>th</sup> century, students with disabilities often missed out on an appropriate educational experience because they received unequal treatment (e.g. higher rates of suspension, school reassignments/transfers, expulsions, etc.) in the public education system compared to their neurotypical peers (Yell et al., 1998).

Parental advocacy had a major impact on the improvement in special education. Starting in the late 1960s, parents of disabled students began to use the law as a vehicle for demanding more educational support for their children. Their goal was to “force states to provide an equal educational opportunity for these students” (Yell et al., 1998, p. 219). One of the biggest roadblock’s parents faced in legal challenges was that education is not a right under the U.S. Constitution (Yell et al., 1998). Without that guarantee, it is difficult to establish a federal mandate to standardize educational policies throughout the states. (VanBergeijk et al., 2008).

Two landmark cases, *Pennsylvania Association for Retarded Citizens (PARC) v. Commonwealth of Pennsylvania*, 343 F Supp.279 (E.D. Pa. 1972) and *Mills v. Board of Education of District of Columbia*, 348 F. Supp. 866 (D.D.C. 1972), helped create the foundation for statutes dealing with disabled students (Black et al., 2016). The court in *PARC*, relying on the decision in *Brown v. Board of Education*, said states have no rational basis to deny education to the plaintiffs and mandated that these students should be provided a free public education, just like neurotypical students (*Pennsylvania Association for Retarded Citizens (PARC) v. Commonwealth of Pennsylvania*, 343 F Supp.279 (E.D. Pa. 1972)). In *Mills*, the federal district court extended this to all students with disabilities (*Mills v. Board of Education of District of Columbia*, 348 F. Supp. 866 (D.D.C. 1972)). Following these decisions, Congress enacted § 504 of the Rehabilitation Act in 1973, which prohibited discrimination against handicapped persons in programs receiving

federal funds (Black et al., 2016). This mandate set the stage for the passage of federal legislation in 1975: The Education for All Handicapped Children Act (EAHCA).

The EAHCA was the first comprehensive federal law regarding education for students with disabilities. This federal legislation combined the strongest features of both federal and state laws. (Yell et al., 1998). The EAHCA required public school students be provided: “(a) nondiscriminatory testing, evaluation, and placement procedures; (b) be educated in the least restrictive environment; (c) procedural due process, including parent involvement; (d) a free education; and (e) an appropriate education” (Yell et al., 1998).

In 1990, the EAHCA was renamed the Individuals with Disabilities Education Act (IDEA)(Yell & Drasgow, 2007). IDEA stresses the importance of transition plans—including identifying and developing goals that need to be accomplished to assist students with disabilities in their postsecondary plans. These legislative developments resulted in public schools moving from exclusion to inclusion of students with disabilities. President Bill Clinton signed a bill reauthorizing and amending the IDEA in 1997, which strengthened the role of parents and students in educational decision-making processes (Turnbull et al., 2002). IDEA remains as the largest legal protection for the education of disabled students, ensuring students receive a free appropriate education and other related services.

### **Special Education Cost**

Federal law requires public schools to educate all children, regardless of ability, but it does not specify what schools must provide (Mclaughlin, 2017). The lack of specific requirements makes it acceptable for school districts that do not have the resources (e.g., time, energy, money, or interest) to provide minimal care to students with intellectual or developmental disabilities. Educating students with disabilities is expensive. Between the cost of one-to-one care and special

services (e.g., speech-language pathologists, occupational therapists, physical therapists, and behavioral therapists), special education budgets strain a typical school district's budget (McLaughlin, 2017). On average, the education of a disabled student costs two times that of the education of an able-bodied neurotypical student (Black et al., 2016). This financial strain explains why high-quality special education programs are rare and often operate in anonymity and/or cost a fortune. Those factors are all made worse by the fact the federal government has never met the requirement established in the EAHCA to cover 40% of all special education costs (McLaughlin, 2017). In the past couple of years, federal funding has fallen below 15% of the average per-pupil expenditure, funding less than half of what the EAHCA stated it would originally fund (Blad, 2020).

### **ASD and Eligibility**

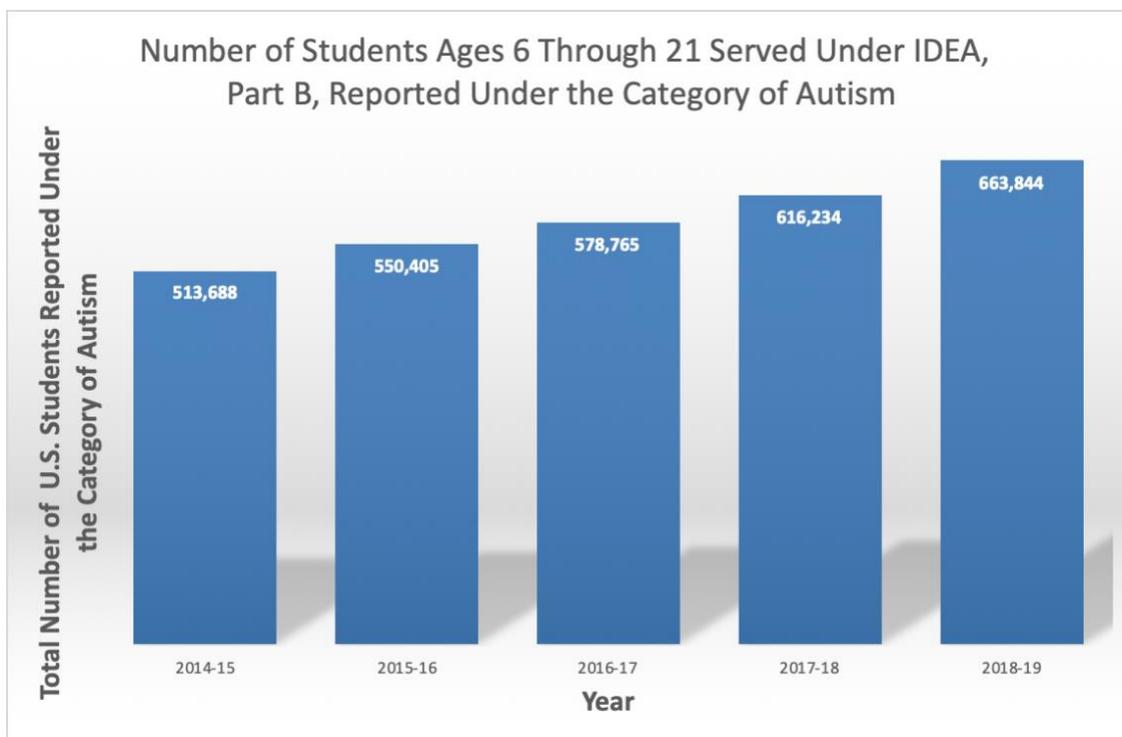
ASD is one of the 13 specific disability categories covered by IDEA. Although IDEA is federally mandated and under the direction of the U.S. Department of Education, it gives states the discretion to determine student eligibility (Nevison & Zahorodny, 2019). One common misconception among parents/caregivers is that a medical diagnosis of one of the 13 disability categories (such as ASD) automatically entitles the student and family special education services under IDEA (Dunn, 2014). Instead, schools make an important distinction between a medical diagnosis and educational eligibility for special services (American Psychiatric Association, 2013). Eligibility for IDEA-covered special education services is based on whether or not a team of professionals deems the student to be in need of special services, in addition to the medical diagnosis made by a doctor or specially trained clinician using symptom criteria described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (Dunn, 2014). Each school has autonomy and convenes its own assessment groups.

Other aspects of a student's identity, such as race, ethnicity, sex, gender, and socioeconomic status (SES) also affect their identification, diagnosis, and eligibility. There are significant racial/ethnic disparities that exist in the recognition of ASD. Children who are American Indian or Alaska Native, Asian, Black; Hispanic, Native Hawaiian or Pacific Islander, or of other non-white race/ethnicities are less likely than white children to be diagnosed with ASD (Mandell et al., 2009). Further, these racial and ethnic minorities suffer from higher rates of delayed diagnosis meaning that they are typically diagnosed with ASD at an older age than white children. Black children, for example, are, on average, diagnosed with ASD three years after white autistic children (Constantino et al., 2020). Non-white children are also more likely to be misdiagnosed with a conduct disorder or a learning disability, leading to the wrong treatment and care (Furfaro, 2017). Both delayed diagnoses and misdiagnoses affect the support and interventions children receive, making the racial disparities detrimental to non-white autistic children and their families.

There are other aspects of one's identity that impact the identification and diagnosis of ASD. The sex and gender of a student is particularly impactful because ASD has historically been considered a male disorder. The ratio of sex commonly reported in literature states that there are four autistic males to every one autistic female (Young et al., 2018). This ratio is now in question as many believe autistic females are being underdiagnosed rather than having ASD at lower rates (Ferri et al., 2018). A better understanding and diagnosis of autistic females is imperative to ensure access to support systems and eligibility for special education services. SES also affects student diagnosis rates and eligibility, with a higher ASD prevalence in children with higher socioeconomic status (Durkin et al., 2010). A child's increased likelihood of being diagnosed with ASD as their SES increases points to a likely SES disparity in access to educational and support services.

These identifiers and their intersections impact each student differently. As schools embark on the implementation of a social model of disability, it is essential that the impact of these diverse identifiers is kept at the forefront of the conversation and helps guide the conversation around appropriate classroom adaptations.

As the prevalence of ASD increases, schools must adjust to serve the increased needs of these students. According to data from the U.S. Department of Education, the number of individuals served by IDEA and reported under the category of ASD has increased in each of the last five years (see Figure 1) (American Psychiatric Association, 2013). Figure 1 displays the steady increase of autistic individuals served under IDEA from 2014-2019.



**Figure 1.** U.S. Department of Education, *EDFacts* Data Warehouse (EDW): “IDEA Part B Child Count and Educational Environments Collection,” Compiled data from 2014-15, 2015-16, 2016-17, 2017-18, 2018-19.

### **The Medical Model of Disability**

Throughout the history of special education, the medical model has been the dominant approach to the education of students with disabilities. The dominance of the medical model of disability can be traced back to late 19<sup>th</sup> century when society began to replace the authority of religious leaders with that of scientists and doctors (Haegele & Hodge, 2016; Koenig, 2012). Before this transition, the moral model of disability — which said people are morally responsible for their own disability because disability was a punishment from God — was the dominant model of disability (Retief & Letšosa, 2018). From the late 19<sup>th</sup> century on, medical professionals controlled the discourse around illnesses and injuries, encompassing any aspect that related to the body and mind, including disability (Brittain, 2004). Because medical professions have the authority to establish disability definitions in society, they also have the power to control how society conceptualizes disability. This has caused disability to become medicalized in America. As an extension of this thinking, people with disabilities are posited as needing treatment, under the care of a doctor, and interventions, like medicine.

As with any medical illness, the medical model looks at disability of the mind (ex. ASD) or body (ex. physical disability) as a problem that needs to be cured for the individual to function like a ‘normal person,’ as recognized by a medical professional (Bingham et al., 2013). Treatment within a medical model of disability typically focuses on fixing the impairment within an individual. Unlike the social model of disability, the medical model implies that there is something inherent to an individual that causes the disability and the impairments are independent of external, environmental factors faced by individuals with disabilities (Haegele & Hodge, 2016).

## **Strengths**

### ***Serves the Majority***

One major strength of the medical model that explains its continued dominance is that this model aligns with societal priorities. To note, the medical model has strength in its efficiency and system alignment, making the strengths largely from an institutional perspective rather than from a student perspective. Society accommodates the needs of the majority and not the needs of the minority. Although the number of students in special education is rising, those with special needs are still a small percentage of the total student population. In 2018-19, students receiving special education services under IDEA made up about 14% of all public-school students (National Center for Education Statistics, 2020). The medical model of disability sees the problem as within the child and tries to mold the child to fit into their neurotypical environment (Massoumeh & Leila, 2012). Although this approach is ableist, it seems more reasonable to claim that the disability is intrinsic to the individual and attempt to “fix” the student, rather than take time and commit resources to identifying and adjusting factors that contribute to the disability, such as systemic barriers, negative attitudes, and exclusion by society.

### ***Service Alignment***

Another strength of approaching the education of autistic students through a medical model of disability is how this model aligns with the current support systems set up for providing resources to students with disabilities. These systems are based on the prevailing medical model of disability and this has allowed for the model to become so dominant within educational settings.

The medical field controls the flow of resources. A diagnosis from a doctor, psychologist, or other medical professional is required to get any support from schools under IDEA (Baglieri & Shapiro, 2012). Matching the medical model approach, the educational system requires a

comprehensive diagnosis before an educational intervention. Additionally, the amount of support a student receives from their school is entirely dependent on the diagnosis the medical professional makes. Since medical professionals are seen as central to this process of labeling students and having a label is the key to the protection of education rights under the current legal regime, it makes sense that the medical model of disability would be central in providing educational support to students with disabilities.

### ***Individualized Educational Programs***

One final strength of the medical model is how a diagnosis from a medical professional informs a student's Individualized Education Program (IEP). An IEP is a legal document protected under IDEA which acts as an individualized educational treatment plan that provides each student with specific tools for maximum benefit (Gael, 2017). IEPs define a student's needs, accommodations, and objectives, including school placement and supplementary aids and services (Ruble & McGrew, 2013). Although there is outdated, dysfunctional language and labels embedded within IEPs, when they function properly, they can create a positive learning environment for autistic students and facilitate access to support services that benefit both the autistic student and their families (Gael, 2017; Kurth et al., 2020).

### **Weaknesses**

#### ***Consequences of Deficit Labeling and Deficit Language***

Approaching the education of autistic students through the medical model has many negative consequences that can affect students mentally, emotionally, and academically. One major weakness of the model is the language it uses to define disability. The definition of disability is important because it influences societal beliefs and expectations, as well as the way society interacts with people who have disabilities. Even the term "ASD", and the definition of ASD as

set forth in the DSM-5, the standardized manual used for psychological conditions in America, includes the word disorder. Disorder means: “a lack of order” (“Disorder,” 2021). “Disorder” is both an inaccurate and illogical description because ASD is not a disordered collection of synonyms, but instead a collection of strategic responses to function in the world (Rubinstein, 2014). Additionally, labeling a person as having a “disorder” has negative effects both on self-image and how society at large thinks about that person (Wendell, 2001). Thirdly, labeling a diagnosis as a “disorder” implies the goal of treatment should be to “re-order” or cure the individual (Rubinstein, 2014).

In addition to the DSM-5’s diagnostic terminology, the medical model of disability defines characteristics of ASD through a deficit view. To understand a diagnosis in terms of deficits is to “(a) conceptualize the phenomenon as a *lack* or *absence* of some feature, trait, capacity, etc. and then (b) characterize this lack or absence as a *deficit* in the feature, trait, capacity, etc. that one *ought* to have” (Dinshak, 2016). Defining an autistic person by their deficits influences how the person feels about themselves and how they are treated by family, teachers, peers, and employers (Sowards, 2015). Research has shown that one of the biggest barriers to successful employment for autistic people is the lack of appropriate understanding and expectations from employers and co-workers (Chen et al., 2015). Additionally, a deficit view of ASD highlights the weaknesses of the diagnosis at the expense and exclusion of the strengths associated with ASD (e.g., ability to absorb and retain facts, expertise in restricted interests, methodical approach, attention to detail, deep focus, resilience, loyalty and integrity, and many more).

This deficit-focused model also generalizes the experience of being autistic, sustaining institutional norms and increasing the likelihood of others discriminating against autistic people (Goering, 2015). One of the most common, non-scientific generalizations about ASD is the

fabrication that autistic people lack empathy and cannot understand emotions (Cohen-Rottenberg, 2011). While autistic people do not always show emotion in ways that neurotypical people do, the idea the autistic people lack empathy and cannot recognize feelings is wrong (Gernsbacher & Yergeau, 2019). In addition to its falseness, the “lack of empathy” stereotype can have dangerous, dehumanizing consequences that distorts how neurotypicals view autistic people (Nicholsen, 2013). Some other perpetuated, deficit-focused generalizations about autistic people are that they lack theory of mind and can’t look others in the eyes (Dinshak, 2016). The consequences of these oversimplified stereotypes are vast (e.g. autistic people might be treated without empathy because neurotypical people think they lack empathy; autistic people might lose opportunities for relationships because neurotypical people think they are incapable of sustaining them) (Cohen-Rottenberg, 2011).

The consequence of the lay-person’s medical understanding of disability is that disabled people often report feeling excluded, underappreciated, and pressured to act like their neurotypical peers (Goering, 2015). Many disabled people express the frustration of being commonly talked to with pity and met with shock when they tell a non-disabled person that they wouldn’t change who they are (Wendell, 2001). Dr. Temple Grandin, an autistic American scientist and advocate, famously said: “If I could snap my fingers and be nonautistic, I would not. ASD is part of what I am” (Jackson, 2010). Often times, the main disadvantage reported by disabled people is not anything related to their impairments, but instead the stigma and ableist attitudes they face in the world (Goering, 2015).

Embedded within the medical model’s deficit focused orientation are negative perceptions of disability (Haegele & Hodge, 2016). The medical model approach of focusing on a student’s deficits highlights what society labels as wrong with them. Being told you are deficient can lower

a student's self-perception of achievement and increase negative attribution, both of which are associated with lowered self-esteem (Kesterson, 2012). The "labeling theory," as described by sociologist Howard Becker, best conveys the effect that labeling autistic students by their deficits can have on their self-esteem. Becker explained that individuals are not naturally different from others until a social group defines them this way (Gill & Maynard, 1995). In other words, the labeling theory suggests that society's perception of an individual has a major impact on how that individual sees themselves. These labeled deficits imply to autistic students that they are lesser than their neurotypical peers as a result of their ASD.

The stigma associated with labeling can lead to other consequences such as parents and/or caregivers refusing to acknowledge a child's needs to avoid having the child labeled (Murphy, 2015). This fear of labeling that stems from society's negative association with disability creates a significant problem: parents and/or caregivers refuse services that, although flawed, might better support their child (Magro, 2019).

### *Normative View*

The medical model of disability is normative. People are viewed as disabled on the basis that they are unable to function in the way that the majority of society considers "normal" (Roush & Sharby, 2011). Consequently, the medical model promotes ableism, defined as discrimination in favor of able-bodied, neurotypical people (Bogart & Dunn, 2019). Multiple theories from psychological, biological, and neurological perspectives have been proposed to explain the cause of ASD. All theories, written through the lens of a medical model of disability, assume deficiencies are inherent to a person and the end goal should be to research these causes in order to modify and minimize impairments within the autistic person (Jaarsma & Welin, 2012).

It is within this normative view that I make a connection between disability theory, queer theory, and critical race theory. Disability, queerness, and non-whiteness, all share a pathologized past within our able-bodied, neurotypical, heterosexual, white dominated society (McRuer, 2006). This normative state within our society causes the mistreatment of others who are looked on as different. Normative views define what is healthy versus sick, clean versus unclean, and natural versus unnatural, all suggesting that deviance from the norm needs to be eliminated or cured (Bauman, 2015). Normativity, supported and emphasized by the medical model, promotes able-bodiedness, heteronormativity, and whiteness. While there are differences in the experiences of each of these identifiers, normativity is problematic and creates negative shared experiences by non-white people, disabled people, and queer people such as medical mistreatment, high rates of violence, stereotypes, discrimination, and other emotional trauma (Sherry, 2004). Additionally, disabled people and queer people often have the shared experience of familial isolation, given that these characteristics may not be shared among family members, as well as familial disapproval and shame (Gutmann Kahn & Lindstrom, 2015). As such, the overlap between queer theory and disability theory is particularly strong.

### ***Ignores Sociocultural Environment***

Another major weakness of the medical model of disability is that it ignores how the problems faced by autistic people in their sociocultural environments can affect their physical, sensory, and cognitive deficits (Brittain, 2004). It focuses on impairments as something inherent to the individual that needs to be cured, rather than focusing on changes to society that would give autistic people the same opportunities as neurotypical people. In a meta-synthesis of published qualitative research studies that investigated the experiences of autistic students in the context of school, Williams et al. (2019) found a large number of autistic students discussed the

inaccessibility of the school environment. They described how the sensory and physical aspects of the school environment made them feel markedly different from their neurotypical peers (Williams et al., 2019). Hallways, entrances/exits, and playgrounds, were mentioned as being particularly stressful places because of their overwhelming noise, unpredictability, and unstructured social interactions these spaces facilitate (Williams et al., 2019). The medical model ignores these environmental factors and frames disability as inherent to the individual.

### ***Educational Priorities***

One of the most detrimental weaknesses of the medical model of disability is the way the current educational approach fails students in the short- and long-term. In addition to lowering autistic students' self-esteem and affecting the way teachers, administrators, and peers treat them, the long-term negative effects of the medical model educational approach are vast. Education in America is believed to be a prerequisite for a good life, so becoming academically trained is a priority for everyone. But the topics that are focused on in school are not tailored to meet the needs of those with special needs. Skills, even ones that are insurmountable for special education students who have lowered cognitive abilities (e.g., algebra, creative writing, geometry) are often prioritized before life skills (e.g., cooking skills, tending to personal hygiene, managing transportation, etc.) that would improve a person's independence and quality of life (Siegel, 2018).

This education pitfall has long-term effects on independence rates for autistic adults. Current independence rates for autistic adults are abysmal, with up to 53% of autistic adults labeled as having a "poor" outcome, meaning the individual is in a residential facility or living with family under close supervision (Howlin et al., 2004). According to national-level data, at least "50% of young adults on the autism spectrum are completely disconnected from any employment or educational opportunities during the first two years after high school" (Kerns et al., 2016, p. 330).

Unfortunately, autistic adults who are employed are typically underemployed, meaning they are poorly paid and given limited hours and fringe benefits (Chen et al., 2015). A longitudinal study by Howlin et al. (2004) found that out of 68 individuals followed from age seven to age 29, only two were working full-time in adulthood (Howlin et al., 2004).

The educational services provided to autistic individuals are inadequate, forcing parents and other caregivers to provide the majority of the social, emotional, and financial support (Howlin & Magiati, 2017). The experience of parenting an autistic child is associated with higher caregiver-reported stress levels, and poor psychological health (Hobson et al., 2016). That stress can negatively affect a family, especially when it includes neurotypical siblings. Furthermore, as the primary caregivers become elderly, they may be unable to support and advocate for their child in the same way they once did.

This struggle to live and cope with inadequate preparation and insufficient services can lead to frustration and lower quality of life for autistic young adults. Autistic people experience a higher prevalence of mental health conditions compared to their neurotypical peers (Weiss et al., 2018). ASD is estimated to be comorbid with psychiatric disorders about 70% of the time, with depression and anxiety being the most common comorbid psychiatric disorders (Kerns et al., 2016).

The needs of autistic individuals have a significant impact on the economy. The cost of ASD for adults can be very high, estimated in America to be about \$3.2 million per each autistic individual over the course of their life and about \$35 billion nationally annually (Volkmar, 2019). Between the increasing rate of diagnosis of ASD and the expensive needs of autistic adults, the economic costs for society in the next decade are likely to grow. Increasing the functional outcome

of autistic individuals improves the individual's quality of life, reduces caregiver stress, and has important economic benefits.

The medical model approach is failing the majority of autistic students. This model defines deficits off of the able-bodied and neurotypical norm. It lacks any consideration of the experience or environment of a disabled student. It is not adequately preparing this population for a successful, fulfilling life after their formal education. In fact, in some cases, this approach might even be causing more harm by enforcing low self-esteem and low self-perception of achievement. The lack of preparation many autistic students receive from their formal education creates other significant effects such as caregiver stress and negative economic impact. Given the medical model's wide-ranging negative consequences, this paper supports the transition to approaching the education of autistic students through the social model of disability. The following section discusses the strengths and weaknesses of the social model of disability. It highlights how the social model's strengths can mitigate the negative consequences of the medical model approach.

### **The Social Model of Disability**

The social model of disability was first defined in 1975, when an early disability rights organization in the United Kingdom, called the Union of the Physically Impaired Against Segregation (UPIAS), released a social definition of disability. UPIAS' definition separated impairment and disability (Oliver, 2013). In the pamphlet, titled "The Fundamental Principles of Disability," the UPIAS stated: "In our view it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society" (Union of the Physically Impaired Against Segregation, 1975). The pamphlet distinguished impairment and disability: impairment is "lacking part of or all of a limb, or having a defective limb, organ or mechanism of the body;" and disability

is “the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities. Physical disability is therefore a particular form of social oppression.” (Union of the Physically Impaired Against Segregation, 1975).

In 1983, disabled academic Mike Oliver formally coined the phrase *social model of disability*, based on the UPIAS ideological definition. Over time, the social model of disability has extended from the physically disabled to include all disabled people, including intellectual and developmental disabilities. The fundamental assumptions of the model are: 1) disabled people are a minority group who are both excluded from and discriminated against by neurotypical society, 2) impairment and disability need to be distinguished because disability is a form of social inequality since society causes disability, not impairments, and 3) it is society’s responsibility to remove obstacles that disabled people face (Waldschmidt, 2018).

The social model sees disability resulting from the social and environmental failure to accommodate the needs of an individual, rather than as a result of the impairment inherent in the individual (den Houting, 2019). The model accounts for the physical, cognitive, and emotional characteristics of the social context and sees disability as a result of the poor fit between an individual and their environment (Levitt, 2017). In addition to acknowledging the tangible environmental and structural changes that would increase inclusivity, making the world more hospitable to autistic people, the social model of disability emphasizes the impact ableist attitudes and systemic barriers have on autistic people (Goering, 2015).

Although the social model of disability has been discussed and promoted by some scholars, it has not gained support from most neurotypical stakeholders (e.g. physicians, psychologists, educators) and some of the language associated with the social model is still debated among

scholars (den Houting, 2019; Haegele & Hodge, 2016). With the neurodiversity movement gaining influence in the ASD community, there have been some shifts in attitude about the social model of disability. Still, the ideology behind the model is not universally accepted.

Treatment within a social model of disability focuses on environmental changes and attitudinal shifts in society. The social model of disability focuses on the removal of systemic, environmental barriers and increasing a greater understanding and acceptance of ASD so that disability, as described by UPIAS, might cease to exist (Brittain, 2004). The social model of disability does not aim to “fix” or “cure” the impairment of an individual. Instead, it focuses on solutions that would improve the quality of life of the individual as well as respect ASD, or any disability, as a natural variation in human life (den Houting, 2019).

## **Strengths**

### ***Representation and Control of Disability Narrative***

A major strength of the social model of disability is it was created by disabled people for disabled people (Union of the Physically Impaired Against Segregation, 1975). Too often, disabled people are left out of conversations related to individual treatment plans or systemic policies (Iezzoni & Long-Bellil, 2012). The social model of disability acknowledges that disabled people know what is best for them since they live with the impairments and face the disabling impacts of society daily. The creation of the social model embodies the mantra: “Nothing about us without us,” a slogan for self-empowerment and self-determination widely adopted by disability rights activists (Iezzoni & Long-Bellil, 2012). Succinctly, the social model supports that there should be no policy or decision made by any representative without full and direct participation of disabled people.

In addition to inclusion, the social model of disability gives disabled people control of the disability narrative (Parsloe, 2015). Through this model, the experience of having a disability is no longer based on the presumptions of able-bodied neurotypical people, but instead from disabled persons themselves. Able-bodied neurotypical people often assume that impairments faced by disabled people are negative, but that may not be how disabled people experience their impairment (Goering, 2015). By centering the voices and experience of disabled people, there is less opportunity for misguided assumptions.

Harriet McBryde Johnson, a disabled author, attorney, and disability-rights activist, describes that in her collection of essays, *Too Late to Die Young*. Johnson employed a personal care attendant for most of her life. In her writing she explained how able-bodied people thought of her reliance on the care attendant as undignified, but she saw it as a beautiful connection that she would have missed if she had a fully independent life (Johnson, 2013). Johnson wrote: “I sometimes think how strange it would be to do these morning things in solitude as non-disabled people do, and to regard, as many of them do, a life like mine as a dreadful and unnatural thing. To me it is so natural to feel the touch of the washcloth-covered hands on flesh that is glad to be flesh, to rejoice that other hands are here...” (Johnson, 2013, p. 251). Giving disabled individuals control of the disability narrative allows for a true description of what having the impairment is like and how disabled people want and need to be supported (Goering, 2015).

Similarly, autistic advocates demand to have a dominant voice in the disability narrative to counteract the stigmatizing depictions of ASD resulting from the medical model of disability, which encourages a “cure” viewpoint (Parsloe, 2015). Autism Self-Advocacy Network (ASAN) and the Autism Network International (ANI) are two of several self-advocacy organizations developed by neurodiversity proponents who support the social model of disability because it

empowers those with ASD to control the discourse around disability and reclaim the experience of being autistic (Bagatell, 2010).

***Empowerment: Socially and Politically***

The social model of disability advocates for disabled people having power and pride rather than stigma and pity. The model empowers disabled people by re-defining what it means to be a person with a disability in all aspects of our society (Iezzoni & Long-Bellil, 2012). Rather than stigmatizing disability as a disease, the social model of disability promotes the neurodiversity perspective in which impairments are seen and appreciated as natural human variations (den Houting, 2019). The social model of disability rejects pathologizing deviance from the norm and challenges social norms that marginalize those who do not conform to the neurotypical, able-bodied standard (Sherry, 2004). Similarly, queer rights activists have long rejected pathologizing sexuality as well as emphasizing the importance of showing pride in their identity and reclaiming words of hate by turning them into words of pride (e.g. queer). The disability rights movement, with the support of the social model of disability, has also used humor as a political tool and reclaimed words of hatred such as “crip” and “gimp” (McRuer, 2006).

Additionally, the social model of disability has played a positive role in the disability rights movement by empowering disabled people at an individual level and as part of a broader, united community. The model holds that disability is not an inherent result of an individual’s impairments, but a social oppression created by society’s response to that impairment, which requires a movement to combat the oppressive marginalization of disabled people. (Winter, 2003). The social model of disability has promoted disabled people’s self-confidence and given the disabled community a strong collective identity. It also provides a path toward political organization with the goal of commitment to social change (Goering, 2015).

### ***Acknowledges and Addresses Barriers***

A major strength of the social model of disability is its acknowledgement of the role that environmental, attitudinal, and institutional/structural factors have in a disabled person's life. Society disables individuals with impairments by upholding inaccessible environments, promoting prejudice and discrimination, and providing inadequate support (den Houting, 2019). The level of inaccessibility of an environment depends on the impairment. Still, on the whole, environments are built to support able-bodied, neurotypical people. For non-weightbearing wheelchair users, environmental barriers in schools often include stairs, narrow door frames, and small bathroom stalls (Gray et al., 2003). For autistic students, barriers might include crowded school hallways or bright florescent overhead lighting (Cunningham, 2020). Not all disabled students experience environmental, attitudinal, and institutional/structural barriers in the same way. For example, disabled students who have comorbid diagnoses and/or whom are also members of other historically disadvantaged groups (e.g., LGBTQIA+; BIPOC) are likely to be at an increased risk of facing compounded discrimination (Darrow, 2009).

In addition to environmental barriers, the social model of disability acknowledges attitudinal barriers that stem from an ableist society. Stigmatization and discrimination arise as a result of misconceptions and stereotypes. These are among the biggest barriers encountered by disabled students. This ignorance denies disabled people the chance to become integrated into society and makes it difficult for disabled students to fully access educational services. In schools, discrimination against disabled students can stem from both neurotypical peers and from adults, like teachers, administrators, and support staff. Disabled students are about twice as likely to experience peer bullying compared to neurotypical peers (25-30% for neurotypicals vs. 50-60% for disabled students) and this number is estimated to be higher for autistic children (~70%) due

to their communication vulnerabilities (Forrest et al., 2020; Zablotzky et al., 2013). In addition to peers, attitudinal barriers are related to teachers and other school employees who often have attitudes and preconceived misconceptions about disabled students (Darrow, 2009). Negative attitudes from teachers and other school employees often stem from a lack of understanding of ASD, caused by misinformation or generalizations, and affect the amount and type of support adults provide autistic students (Cunningham, 2020).

Lastly, the social model of disability addresses institutional/structural barriers that systematically disadvantage disabled people through policies, practices, and other norms that favor able-bodied neurotypical people (den Houting, 2019). In educational settings, institutional or structural barriers can manifest in inadequate funding, classroom structure, or educational expectations (Cunningham, 2020; Olson & Roberts, 2020).

## **Weaknesses**

### ***Misinterpretation***

The fundamental principles of the social model of disability are frequently misunderstood. That is one of its biggest weaknesses and creates a major barrier in convincing stakeholders to implement the model. One way the social model of disability is misinterpreted that the model is often wrongly thought of as claiming that autistic people do not need support whatsoever (Owens, 2015). This misconception stems from critics of the social model who claim the model frames ASD as a cultural identity instead of a disability (Haegele & Hodge, 2016). The social model of disability does not claim that ASD is not a disability. Instead shifts the root cause of disability as to environmental, attitudinal, and institutional barriers rather than the impairment itself (den Houting, 2019). This misinterpretation disregards the social model's fight for appropriate support and related services that meet the needs of the autistic community by only considering the model's

campaign of acceptance of neurodiversity and respect for autistic people (Haegele & Hodge, 2016).

### ***Ignores the Relationship Between Impairment and Disability***

Another weakness of the social model of disability is that it separates impairments from disability. Disability and impairments are intrinsically linked. By separating these attributes the model fails to fully address how the impairment itself can affect an individual's life (Bingham et al., 2013). Impairments are an observable feature of a disabled person's life and an essential aspect of their lived experience (Palmer & Harley, 2012). The social model ignores impairments and focuses solely on disability, which does not entirely account for the lived experiences of disabled people, as it negates the experience of pain and deficits (Haegele & Hodge, 2016).

### ***Race Neutral***

The social model of disability is race-neutral and, as such, de facto white. This renders it primarily applicable to the experiences of white disabled people. The social model fails to consider race, or other identifiers, as it presents disabled people as a uniform group. Oliver, the disabled activist that coined the social model of disability, has acknowledged that even at the onset he knew the model was not an all-encompassing framework as it fails to address race, gender, sexuality, and age (Oliver, 2013). Oliver had hoped that the social model of disability would be viewed as a surface level framework within which medical professionals should begin to re-orient their work. Before it can be considered inclusive to all disabled people, the social model of disability will need to be reworked and expanded to address how certain barriers to access intersect with racial and ethnic identities.

### ***An Inclusive Model that Excludes***

The social model of disability excludes individuals with certain impairments in its emphasis to change environmental barriers. The social model of disability was initially created for physically impaired individuals and only later extended to include all disabled people (Levitt, 2017). This extension, which occurred without much change in language or ideology of the model, created barriers for certain impairments to be included within the model. For example, the model might exclude disabilities that cannot be easily fixed by providing a more accommodating environment (e.g. chronic fatigue, learning disabilities, anxiety, chronic pain) (Jaarsma & Welin, 2012). Importantly, even though the social model excludes impairments that cannot be fixed by changing the physical environment, the model also emphasized the importance of adapting social environment. Since almost all disabled people face attitudinal barriers from society, this approach has an expansive impact and is inclusive (Owens, 2015).

Because the model is difficult to extend to certain impairments, the model is often wrongly thought to include only autistic people who need less support, often labeled as “high functioning autistics” (den Houting, 2019). The misleading notion is that some autistic people are too disabled to be able to benefit from the social model of disability (Jaarsma & Welin, 2012). Even autistic people who need the highest levels of support can benefit from the social model of disability. Disability can still be moderated and even minimized through environmental changes, as well as changes to address attitudinal and structural barriers (den Houting, 2019).

### **Preliminary Implementation Ideas**

Despite the merits of the social model of disability, the model remains underutilized and undervalued, in educational settings and society at large. Until the social model of disability is more widely accepted, it is unreasonable to imagine that the American education system would

displace the medical model of disability with the social model. Nevertheless, the rapid integration of the social model of disability within classrooms to minimize further damage to disabled students is possible and necessary. In the following sections, I offer preliminary implementation ideas that address how elementary school teachers can integrate the social model of disability into their classrooms, to reduce environmental, attitudinal, and institutional/structural barriers to the education of autistic students. These implementations are applicable to an integrated classroom and to a special education or autistic specific classroom.

My preliminary implementation ideas – divided into environmental, attitudinal, and institutional/structural suggestions – were informed by informal consultations with special education educators and administrators, as well as through my analysis of the medical model of disability, the social model of disability, disability theory, queer theory, and critical race theory. This section is not exhaustive. I aim to provide a basic overview of some of the many ways’ that teachers can implement changes within their classrooms to lessen external barriers and make schools more welcoming places for autistic students.

### **Environmental Changes**

The average school environment is not hospitable to autistic students (Williams et al., 2019). Between the overstimulating noise and unpredictability of social situations, autistic students spend a large amount of their daily life coping with a hostile school environment (Rudy, 2020). This stress can lead autistic students to resort to maladaptive strategies, such as hiding in the bathroom or even refusing to go to school, to escape overstimulation and stress (Goodall, 2020; Howlin et al., 2004). The small changes discussed next are actionable steps teachers can implement in the physical classroom environment to better support autistic students’ sensory processing systems. These simple changes will make the classroom more attuned to the needs of autistic

students, leading to better academic and emotional outcomes for this population (Denning & Moody, 2013).

### ***Sensory Room to Destress***

To address the overstimulation of school environments, schools should designate sensory areas or rooms that serves as a safe space to destress. When asked how their school could have improved their educational experience, one of autistic students' most frequent recommendations is by providing a safe space to relax and destress (Goodall, 2020). Sensory rooms provide autistic students the ability to control the amount of stimulation they receive and allow overstimulated students to destress (Love, 2019). Equipment for sensory rooms is relatively inexpensive. Therapy balls, sensory bins (plastic containers filled with rice and dried beans), and bean bag chairs are just a few of the many low-cost types of equipment found in sensory rooms (Ray, 2017). In addition to the creation of a sensory room, the utilization of the space is equally as important. Sensory rooms should not be a reward or a punishment, but instead a choice for autistic students to make for themselves when they feel they need to destress and feel safe (Ray, 2017). By not tying the space to a behavior – like a reward or punishment – the safety and accessibility of the sensory area will be maintained.

### ***Classroom Design and Sensory Strategies***

Other environmental changes are the design and aesthetics of the classroom. Educators often focus so intently on student behavior as an indicator of an individual problem that they forget to gauge the classroom's physical environment as a contributing factor to a student's temperament (Block, 2018). Environmental factors include lighting, color, acoustics, and room arrangement. Taylor (2009) defines these attributes as “a silent curriculum.” McAllister & Sloan (2016) identify

them as important factors to consider when creating an ideal learning environment for autistic students.

**Light.** Bright fluorescent lights, one of the most common lighting systems in American public schools, can cause sensory overload (Marco et al., 2011). Dimming the light minimizes sensory overload caused by lights. Alternative solutions are to not turn on every light in a classroom or to drape a dimming piece of fabric over bright lights.

**Color.** Painting or draping a room in a calming color, covering book shelves with plain fabric, turning off computers, and cleanings whiteboards can reduce the level of stimulation in a room (Centre for Autism Middletown, 2021).

**Acoustics.** Noise from fans, windows, doors, and other students can be distracting and negatively influence student behavior, as well as academic performance (Block, 2018). Seating autistic students away from auditory distractions, using carpets and rugs, and turning off noisy equipment are simple strategies that can reduce auditory stimulation and make the classroom a more inviting place for autistic students (Centre for Autism Middletown, 2021).

**Room Arrangement.** When considering room arrangement, teachers should prioritize spatial sequencing. The classroom should be set up in a logical order based on the student's schedule to enable a seamless flow from one activity to the next. Further, spaces should be clutter-free (Block, 2018).

### ***Utilize a Visible Schedule***

Visible schedules communicate the timeline of events through words and/or pictures (Denning & Moody, 2013). Schedules can be more general and posted in a central location in the classroom or students might have individualized schedules attached to their folders or desks. By using general and/or individualized visible schedules, teachers can counteract the increased

anxiety autistic students might face with unstructured time (Cunningham, 2020). A visible schedule of the day's activities gives students an idea of what to expect next by providing predictable outcomes (Block, 2018).

### **Attitudinal Changes**

Attitudinal barriers express the ableist beliefs and attitudes that neurotypical peers, teachers, and other school employees have about autistic students. Negative attitudes typically take the form of stigmatization and discrimination. They stem largely from ignorance and misconceptions (Cunningham, 2020). Attitudinal barriers deny autistic students the opportunity to successfully socially integrate and make it difficult for autistic student to access equitable education services. Below are some actionable changes teachers can implement within the classroom to lessen the attitudinal barriers for autistic students within schools.

### ***Psychoeducation***

**Teachers and Other School Staff.** Teachers, and all school staff members who interact with autistic students, must take the initiative to educate themselves about the experiences of ASD. This education should not be limited to how ASD affects a student's life, and should include how to best support autistic students (Saravanakumar et al., 2011). Psychoeducation can occur in formal environments, such as meeting with psychologists or attending a conference or class, or can occur informally through the daily interactions with autistic students and their families (Montoya et al., 2011). Professional development (PD) days are another avenue through which teachers can receive psychoeducation. That requires support of district administrators who typically determine the PD curriculum. PD generally refers to continuing learning opportunities available to teachers through their schools and allow teachers to expand their knowledge base on a variety of subjects (Bryant et al., 2001).

Teachers must identify and work to actively change any ableist beliefs that, explicitly or implicitly, impact the way they interact with autistic students and their families. Teachers might hold a variety of opinions about autistic students in the classroom and those attitudes impact how autistic students are treated in the classroom. Autistic students deserve teachers who have high expectations about their ability and work to support their learning and development, free of stereotypes. Additionally, the attitudes of neurotypical students toward autistic students often reflect the attitudes modeled by teachers. It is of the utmost importance that teachers model respect, positive language, and anti-ableism (Darrow, 2009). This is of heightened importance in mixed classrooms, which include neurotypical and autistic students.

Autistics students are not a monolith. Teachers should make it common practice to ask autistic students' what terminology they prefer (person-first versus identity-first) and respect their opinion by addressing them as they choose. ASD is a huge spectrum: just as every neurotypical child is different, so is every autistic student. What works for one autistic student is not guaranteed to work for the next. Teachers should communicate often with autistic students and their families to ensure the teachers are meeting students' needs.

**Students.** The earlier neurotypical students are taught about ASD, and disability as a whole, the better. Often teachers think it's best to wait until they believe students are ready to comprehend disability. In waiting, teachers underestimate children's ability to understand complex topics and make it increasingly harder to have an open conversation about disability (George, 2018). If autistic students can grow up understanding they are different from a very young age, neurotypical students can also comprehend how they differ from autistic students from a very young age. As early in development as possible, students should be introduced to disability as a natural human variation that deserves respect and empathy. Conversations about disabilities should be a norm

within elementary school curriculums. Teachers should explore different ways to encourage neurotypical students to understand their autistic peers.

Some suggestions for explaining ASD to young children are to 1) start as basically as possible, by explaining neurodiversity and how autistic brains work differently than neurotypical brains; 2) give concrete examples about how an autistic student might react differently to a situation compared to a neurotypical student; and 3) let students ask questions and encourage an open conversation about ASD (George, 2018).

Autistic students and their families should always have a voice in framing how teachers explain ASD to their neurotypical peers, but should never have the burden of leading the conversations. Those conversations must balance talking about this important subject and making sure autistic students are not burdened with being representatives of ASD for their classroom. Teachers could have potentially harmful conversations (e.g., by perpetuating dangerous stereotypes) within their classrooms if they do not think through or understand the impact that conversations can have on autistic students and their neurotypical peers. To have meaningful and well-informed conversations, teachers will need to be properly trained to learn strategies for how to accomplish their goals in a knowledgeable and inclusive manner.

### **Institutional/Structural Changes**

Institutional/structural barriers to education are found in policies, procedures, and organizational structures that systemically disadvantage autistic students (Seaver, 2016). These barriers include building procedures, curriculum design, and a lack of proper accommodations. Below are some changes teachers can implement within the classroom to lessen the institutional/structural barriers for autistic students. To successfully implement institutional/structural changes, teachers must have ongoing consultations or coaching with trained

professionals to understand and implement meaningful social model changes. Teachers will need help identifying and adjusting institutional/structural barriers within the classroom. They will be able to do so successfully only with a high amount of support from administrators.

### ***Entrance/Exits***

School hallways and entrances/exits can be particularly debilitating spaces for autistic students because of their unpredictability and noise level (Hebron & Humphrey, 2014). An institutional/structural change that teachers can implement to counteract the heightened noise and anxiety associated with entrances/exits is to have autistic students use an alternative entrance/exit which would be quieter and more controlled. That gives autistic students choice and time to process a sensory change (Love, 2019). Alternatively, students can have delayed start/end times for school or class, so that their passing times do not overlap with the majority of students, which reduces the amount of unpredictability and noise.

### ***Enhance IEPs***

Every autistic student is legally required to have an IEP, which makes those plans an ideal means for teachers to incorporate ideas from the social model of disability. IEPs describe how the general education curriculum will be modified to meet the needs of the specific child, identify what additional aids and services the child needs, and list specific areas for inclusion (Huzinec, 2016). In each of those sections, IEP drafters should think about the external barriers autistic students face and how they can best craft support systems into a student's IEP that combats these barriers.

### ***Curriculum Enhancement***

**Strengths-based Approach.** Teachers should implement a strengths-based approach to the curriculum that acknowledges and utilizes the skills, knowledge, and capacity of autistic

students. The medical model approach to autistic education has largely ignored autistic students' cognitive strengths, talents, and diverse way of being. A strengths-based approach, which aligns with the social model of disability's ethos, would shift toward focusing on the strengths of autistic students and utilizing strategies that highlight strengths to support learning and development. That is not the same as ignoring challenges. Instead, the approach encourages less focus on the traditional methods of education that often fail autistic students (Pattoni, 2012). Importantly, a strengths-based approach requires teachers to adopt a flexible pedagogical approach: not every strategy that works with one autistic student will work with every autistic student.

**Hands-On Learning & Variety.** The traditional learning experience consists of teachers giving whole-group instruction through knowledge transfer (Schwartz et al., 2005). That “one-size-fits-all” approach fails to account for the different needs of each student within a classroom. Autistic students thrive when teachers use a variety of instructional activities that allow students to physically engage in lessons and participate (Leach & Duffy, 2009). Hands-on learning is a great example of a physically engaging learning experience: it uses perceptual-motor intelligence to give meaning to words and symbols (Schwartz et al., 2016). Teachers with autistic students should implement hands-on learning activities into their lesson plans to increase engagement, allow for movement and fidgeting, and capitalize on autistic students' ability to think and learn in a visual way (Block, 2018). That final element – capitalizing on autistic students' ability to think and learn in a visual manner – is also an example of strengths-based learning.

**Restricted Interests.** Restricted interests (RIs) in a particular topic are an indicator of an ASD diagnosis (American Psychiatric Association, 2013). Teachers commonly avoid or restrict the use of RIs in the classroom (Gunn & Delafield-Butt, 2016). Rather than keeping RIs out of the classroom, teachers should incorporate autistic students' RIs into the curriculum. For example, if

a child has an RI in dinosaurs, teachers could use dinosaurs in math problems, read about dinosaurs for English language arts (ELA), implement dinosaurs into the history curriculum, and encourage the child to write a story about dinosaurs. Embedding RIs into an autistic child's curriculum is an effective motivator that increases engagement and enjoyment in learning (Mancil & Pearl, 2008). A meta-analysis of 20 published studies between 1990-2014 found gains in education attainment and/or social engagement for all 91 children examined when RIs were implemented and utilized in learning (Gunn & Delafield-Butt, 2016). Despite RIs being labeled as a negative attribute associated with ASD, RIs can be used to motivate children in the classroom to improve engagement, enjoyment, and educational attainment.

### **Limitations**

#### **Presented as a Binary Option**

One limitation of this paper is that the analysis of the medical model and the social model engenders a problematic binary choice. That unintended consequence stems from comparing and contrasting the models, which can lead to the reader assuming one must choose the medical model or entirely replace it with the social model. Still, the comparison of the two models was important to address the common understanding of each model, conceptualize the problems autistic students face in their education, and identify how these problems should be addressed.

That binary choice is not uncommon. The social model of disability is often portrayed in scholarship as being contradictory to other models. Part of the issue reflects the society within which the model is introduced (Jaarsma & Welin, 2012). Many neurotypical stakeholders (doctors, teachers, and family members) are firmly committed to the medical model and, further, have adapted to find their space in that system. Any mention of the social model is perceived as a replacement, or a threat. Entirely replacing the medical model with the social model feels

impossible, even for the strongest of social model advocates. Further, there is a place/need for both models within our society. New thinking needs to be done to join these models and identify how to extract the best of both models to build more robust and nuanced support systems for autistic students.

This paper compared the two models not to present a binary option, but to address the strengths and weaknesses of each model and point out the urgent need for teachers to include and utilize the social model of disability in their classrooms. I hope this paper can help pave the way for future discourse on how schools can include and draw from the strengths of the social model, to provide a comprehensive view of disability that recognizes the impact of the external world and addresses barriers to better support autistic students.

### **Lack of Autistic Voices**

The negative schooling experiences shared by many of the autistic adults I had the opportunity of meeting with during group therapy sessions last summer was the primary inspiration for this capstone. However, because of the scope and timeframe of this project, I did not consult with or have informal conversations with autistic students about the social model of disability. While my preliminary implementations section was informed by informal consultations with special education educators and administrators, the lack of informal consultations with autistic individuals might limit the effectiveness of these proposals. The preliminary implementations sections did include perspectives from autistic students from research journals (Cunningham, 2020; Goodall, 2020; Love, 2019). Still, this paper and the quality of my implementations would likely have been improved if I had also spoken directly with autistic students to understand their views, thoughts and feelings and incorporate their feedback.

## **Implementation at the Classroom Level**

I chose to have my preliminary implementations at the classroom level because change is slow on the structural level and improving the education of autistic individuals is time-sensitive. My hope is that by beginning in the classroom, the social model could become adopted and normalized among teachers, lowering the barriers of change to larger-scale interventions at the school, district, state, and national levels. That decision is, in and of itself, a limitation for two reasons. From a practical perspective, my suggestions are limited to the elementary school space. Further, on a more philosophical level, teachers do not exist in isolation and often have constraints they must comply with. I acknowledged earlier that the context and/or climate of a school and its leadership can prevent even the best educators from successful implementation of even the best and most well-thought-out practices. I recognize implementation at a classroom level is a challenging task. My hope is that by starting at this level, teachers would be able to have a larger, more efficient impact on an individual basis.

## **Personal Bias**

One final limitation has to do with my own bias. I am a strong advocate of the social model of disability. I acknowledge that, even when trying to be impartial, my writing is colored by my beliefs and experiences.

## **Suggestions for Future Research**

### **Consult with Autistic Students**

Future research should consult directly with autistic students about the social model of disability and their thoughts on how to best instrumentalize this model to support autistic students. Until researchers engage with autistic students and listen to what they have to say, we will be unlikely to fully provide them with the support they need or an equitable education.

## **Comprehensive Classroom Implementation Guide**

Due to the limited scope and timeline of this capstone, the implementation suggestions are a non-exhaustive list that represent preliminary suggestions. Future research should aim to create a comprehensive implementation guide for teachers within the classroom.

### **Implementations at All Levels**

My capstone discussed implementations for teachers within the elementary school classroom. However, for a successful inclusion of the social model of disability, future research should create implementations at the grade-wide, school-wide, district-wide, state-wide, nation-wide levels.

### **Extending the Model to All Differences**

This capstone focused on autistic students, but my research raised the many ways in which educational systems exclude other kinds of difference (e.g., race, LGBTQIA+, disabilities outside of ASD). Future research should apply the social model of disability to all differences to create more equitable treatment and education in schools. There are differences upheld in our society by systemic racist, homophobic, and ableist beliefs that are explicitly and implicitly held by those in power (cisgender, straight, white, able-bodied people). To address that problem, future research on applying the social model to other kinds of differences should be paired with implicit and explicit bias training.

### **Social Model Within the World**

This capstone introduced the social model of disability into educational settings with the limited scope of autistic students and elementary school classrooms, but the social model has a place in the larger world for all disabled people. Future research should address implementing this model across all public places, beyond the educational realm. The social model sees disability as

a result of the environment failing to accommodate the needs of an individual. By decreasing the external barriers within a disabled individual's environment, we can lessen the disabling effects of society. Only then will the world be a more equitable and inviting place for disabled people.

### **Conclusion**

The goal of my Education Studies capstone was to analyze the medical model and social model and discuss their implications for autistic students. This work was inspired by the shared feeling of frustration with the K-12 education experienced by many of the autistic adults who attended my group therapy research sessions over the summer. I provided preliminary suggestions, rooted in a social model of disability, that elementary school teachers could and should incorporate into educational practices within their classrooms. While the United States has made great strides in the educational opportunities provided to autistic students over the last half-century, the dominant medical model approach is failing autistic students by focusing on their deficits and ignoring harmful external factors.

ASD should be accepted as a normal human variation. It should be accepted as one that does not need to be cured or fixed, but instead should be supported through environmental, attitudinal, and institutional/structural change, so autistic individuals can finally achieve their full potential. Accessibility and support should be given as an act of love and commitment, not a burden or afterthought. The work toward a social model of disability in classrooms is just beginning. I hope my capstone serves as a rudimentary step toward a more robust and comprehensive implementation guide. True implementation of this theory will take time and care, but when implemented its impact on autistic students will be everlasting.

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