

# Transformative Learning Based on Disability: My Disrupting Dilemma

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**Abstract:** A social work educator's experience of temporary disability that was precipitated by an intra-operative femoral fracture creates a disruptive dilemma leading to a process of transformative learning. According to Mezirow (1991, 1994), a disorienting dilemma is precipitated by a life experience which induces powerful emotional responses and results in a recognition that our old ways of thinking and acting are no longer sufficient. This disrupting dilemma is the beginning of a learning process according to Mezirow's phases of transformative learning, including critical reflection on living with a disability, social norms, and the psychosocial impact of ableism. Transformative learning leads to a pedagogical approach that facilitates critical discussion and reflection and allows for learning that integrates the ways in which assumptions about people with disabilities shape individual beliefs, values, and behaviors, and it makes space for the consideration of alternative perspectives that can be applied to social work practice.

**Keywords:** transformative learning, disability, disruptive dilemma, ableism

## Introduction

The summer of 2015 brought with it an unexpected challenge that I have come to understand as a disorienting dilemma leading to transformative learning (Mezirow, 1991). That summer, I experienced life as a disabled person, resulting in profound changes in my cognitive and emotional consciousness. As a social work practitioner and educator for over 20 years, who trained in the generalist model of social work practice, I thought I had a solid working knowledge of disability and the ecosystem implications that come with daily life as a person who is differently abled, but I was wrong. Even though I had experience as a medical social worker, I still had much to learn.

For several years, I experienced aching, throbbing, stiffness, and shooting pains in my lower back, right hip, and right leg, which hindered my ability to walk. I managed to ignore the pain for a long time, rationalizing that I had muscle strain and just needed to stretch. I didn't want to acknowledge that I was not in perfect health. The idea that I might need to depend on someone or something other than my own body invoked fear and anxiety, which I masked by denial and avoidance. I now understand that the overwhelming physical and emotional vulnerability I felt could be traced to a lifetime of internalizing messages that to be less than healthy and whole is somehow unworthy.

When I finally saw a doctor, I was diagnosed with osteoarthritis in my hip. I was advised to get an ultrasound-guided intra-articular injection directly into the hip joint to alleviate the pain, but I was warned that the results would be temporary. I felt immediate relief after getting the injection and resumed my life living in an illusory bubble of perfect health. As long as the injection worked, I did not have to confront the reality that my body was in chronic pain. I repeated this procedure two more times, with each period of relief getting shorter and less effective. When I

called to schedule a fourth procedure, I was told that I could not receive another injection. In fact, the injections may have caused further joint damage even as the pain was alleviated. I swallowed hard, and I contemplated the recommended total hip replacement with trepidation even as I was assured that hip replacement is the most common orthopaedic operation and that the results are generally favorable for a woman in her mid-50s with no complicating medical conditions.

### **An Unexpected Challenge**

Once I accepted that surgery was the final option for alleviating the excruciating pain I now lived with on a daily basis, I began looking forward to the operation. I imagined myself moving pain-free and engaging in activities that I had not been able to do for a long time. I was convinced that I would recover quickly and be on my feet within a few short weeks. I envisioned myself walking, hiking, and horseback riding—all the things I slowly let go of over the past few years due to the increasing level of pain. I was so optimistic that I scheduled dates for activities a few weeks after surgery, which would have required me to be fully healed in order to drive, walk, and spend a good amount of time on my feet.

As I was wheeled into the operating room, I remember feeling gleeful anticipation at the prospect of regaining my health. Upon waking up in the hospital bed the next morning, I remember feeling relief that it was finally over, that my hip was fixed, and that I would shortly resume what I envisioned as my normal life. I immediately called my husband to let him know I was awake and all was well. Hesitantly, he asked if the doctor had been to see me. Haltingly, he told me my femur fractured during the procedure. I was still groggy at the time, which accounted for my complete lack of comprehension of what this would mean for my recovery.

The doctor informed me that I had experienced an intra-operative femoral fracture, which is a serious complication of total hip replacement surgery. The fracture occurred during the insertion of the femoral component of the artificial prosthesis that is used to reconstruct the hip joint. This necessitated the use of an encircling wire around the femur to hold the bone together while it mended. I learned that this is a rare event affecting less than 5% of hip replacement surgeries.

The femur is the largest bone in the body and requires an extended period of time to heal. The doctor told me that I could not put any weight on my leg, referring to this as touch-toe weight-bearing. I would need to use a walker for a minimum of six weeks without putting any weight on that leg. I could only place my toe lightly on the floor for balance and hop on the other leg while using the walker for mobility. After six weeks, I would be reevaluated and possibly transition to a cane for the next few months of recovery.

After spending a few uncomfortable days in the hospital, I was admitted to a rehabilitation facility where I learned how to use a walker safely, began a gentle exercise program, and practiced activities of daily living. My body, mind, and spirit were slow to grasp the implications of this new reality. As I slowly realized that I was disabled and would need help for the foreseeable future, I experienced a range of emotions from disbelief to anger to distress and desperation.

## **The Americans with Disabilities Act of 1990**

The Americans with Disabilities Act of 1990 (ADA) defines disability as a physical or mental impairment that substantially limits one or more major life activities (United States Department of Justice, Civil Rights Division, n.d.). The ADA does not specifically name all of the impairments that are covered; rather, the ADA considers disability as an umbrella term for impairments, activity limitations, and participation restrictions. After my surgery, I joined the 33 million Americans who have a disability that makes it difficult to carry out daily activities and who need help with their daily care, and I joined the 6.5 million people who have limitations associated with ambulatory activities of the lower body, including difficulty walking, climbing stairs, and using a cane, crutches, and walker (National Institute for Child Health and Human Development, 2016).

Arthritis, also known as degenerative joint disease, is the main cause of disability in the United States, and according to a report from the Arthritis Foundation (2017), more than 50 million adults have been doctor-diagnosed with some type of arthritis. Common arthritic joint symptoms include swelling, pain, stiffness, and decreased range of motion, which result in chronic pain with increasing severity, inability to engage in daily activities, and difficulty walking and climbing stairs. Not only is physical health affected, but based on the Arthritis Foundation's report of Murphy's findings, "about one in three U.S. adults with arthritis, 45 years and older, report having anxiety or depression" (as cited in Arthritis Foundation, 2018, p. 9).

## **Transformative Learning Theory**

The realization that I was disabled was the beginning of a disorienting dilemma, which led to a process of transformative learning. According to Mezirow (1994, 2000, 2003), a disorienting dilemma is precipitated by a life experience, usually a personal crisis, which induces powerful emotional responses and results in a recognition that our old ways of thinking and acting are no longer sufficient. This type of experience has the potential to generate deeper and more insightful ways of understanding and making meaning of ourselves and our experiences in the world (Mezirow, 2003).

Mezirow is the leading proponent of the theory of transformative learning. Theories of transformation are conceptualized as learning that integrates our experiences of the outer world with the experience of our inner worlds (Dirkx, 2008; Dirkx, Mezirow, & Cranston, 2006), learning experiences which shape the learner and produce a significant impact or paradigm shift (Clark, 1993), and an orientation to learning and knowing that is often accompanied by a change in assumptions, beliefs, and values (Witkin, 2014).

Mezirow (2000) believes a prerequisite for transformative learning is to bring long-held frames of reference into awareness. This enables learners to critically reflect on their frames, become aware of how they restrict their thinking, and act in new ways to redefine their world. Mezirow (1994) suggests that this type of learning follows a process of identifiable phases, which result in cognitive, emotional, and behavioral changes, which result in a transformation of how we make meaning of experience. My process closely resembled Mezirow's phases of transformative

learning. The phases are:

1. a disorienting dilemma;
2. a self-examination with feelings of guilt or shame;
3. a critical assessment of epistemic, sociocultural, or psychic assumptions;
4. recognition that one's discontent and the process of transformation are shared and that others have negotiated a similar change;
5. exploration of options for new roles, relationships, and actions;
6. planning a course of action;
7. acquisition of knowledge and skills for implementing one's plan;
8. provisional trying of new roles;
9. building competence and self-confidence in new roles and relationships; and
10. a reintegration into one's life on the basis of conditions dictated by one's perspective (Mezirow, 2000).

The phases follow a progression beginning with the first phase of a disorienting dilemma, which can range from a gradual awareness over a period of time or an abrupt personal crisis—both leading to a disconnection between our meaning structure and our environment. The next two phases involve critical reflection into deep levels of cognitive and emotional states. The next two phases represent rational discourse through contact and communication with others who assist in the exploration of the disorienting dilemma. The final phases involve increasing activity and action leading to the integration of newly discovered knowledge and meaning in one's life. The process of reflectivity is central to transformative learning in that “taken-for-granted cultural or psychological assumptions” (Mezirow, 1981, p. 13) are deeply examined.

### **Phases of Transformative Learning**

As I healed over the course of a year, I experienced painful and powerful emotional responses, which resulted in a shift in meaning that my previous ways of thinking and acting did not sufficiently explain. I discovered that my experiences created pathways to deepening my perceptions and generating more insightful ways of making meaning of disability, both on individual and societal levels. I had time to reflect on living with a disability, my identity and place in society, and the discrimination that I encountered in various settings. Ableism became a personal part of my world, and my body, mind, and spirit were impacted by the discrimination and social prejudice against people with disabilities, which I had not previously encountered. The following section presents an application of Mezirow's (2000) ten phases of transformative learning that I experienced based on my disability.

#### **1. A Disorienting Dilemma**

The realization that I was disabled and would need substantial help for an extended period of time was disorienting and precipitated a crisis in maintaining my identity as an independent adult woman. My disorientation was learning to see through the cultural lens of disability. The circumstances were beyond my control, and I was frustrated by the limitations imposed by using a walker to support my weight as I navigated physical spaces. I was surprised when spaces were

not accessible, and I remember my fear of falling when encountering a curb or being stuck and unable to go up or down steps. While I had an intellectual understanding that I could expect a full recovery, the intensity of my feeling of vulnerability was a palpable sensation, which clashed with my sense of self as a capable, self-sufficient woman. It was this clash that triggered a disrupting dilemma with the ensuing feelings of anxiety and depression.

## **2. Self-Examination with Feelings of Guilt or Shame**

I felt shame at being disabled and guilt about my reaction to this new reality. I experienced a range of emotions, including frustration, fear, hopelessness, anxiety, and depression. I had difficulty asking for help, preferring to struggle with minor activities rather than appear incapable, and I struggled to maintain self-esteem. Through the difficulties of my recovery period, I had to acknowledge the painful awareness that I had bought into the belief that being able-bodied is the normal human condition while, in contrast, being “disabled” is linked to ill health, incapacity, and dependence (McLean, 2011). These feelings were indicative of an unconscious, internalized belief that disability is something that happens to other people. Realizing that I participate in an ableist society (where most people, if not everyone, are shaped by prejudice toward individuals with disabilities) was difficult to accept. I had to change my frame of reference to accept that disability is not a deficit or personal failing but can happen to anyone at any time.

## **3. A Critical Assessment of Epistemic, Sociocultural, or Psychic Assumptions**

The discomfort I experienced asking for help led me to a more critical assessment of the ways that societal norms value bodies that can function independently without a need for assistance. This was brought to my attention when I encountered a coworker who vehemently exclaimed, “I hate seeing you this way!” I became acutely aware of the social constructions that cast people with disabilities as damaged objects by “simply moving through their everyday environments, in addition to the concrete aspects of physical limitations and discomfort in their daily life,” (Michilin & Juarez-Marazzo, 2007, p. 206).

## **4. Recognition That One’s Discontent and the Process of Transformation Are Shared and That Others Have Negotiated a Similar Change**

The time I spent in the rehabilitation facility allowed me to experience a sense of community and connection with others who were experiencing similar challenges navigating physical space due to knee or hip replacements and other various chronic conditions. I had conversations with patients and medical staff, which helped me cope with my feelings and decrease my anxiety and emotional isolation. Physical and occupational therapy taught me alternative methods to manage daily activities. The feeling of isolation was alleviated by knowing that others had experienced what I was experiencing and had learned to cope and find alternative, often creative, ways to meet their needs.

## **5. Exploration of Options for New Roles, Relationships, and Actions**

My disability had a large impact on my family members as they were also impacted by the changes in household routines. Family roles were forced to accommodate the need to maintain household tasks and responsibilities. Trying to manage through these changes was an ongoing effort that strained relationships and caused an imbalance in otherwise stable relationships. It was difficult to acknowledge that my disability was perceived negatively at times and caused anxiety within my family system. Improving family communication became a major activity in order to increase mutual understanding and support while acknowledging and negotiating different needs and perspectives.

## **6. Planning a Course of Action**

With the approach of the fall semester, I contemplated my options for returning to my position as a faculty member (with the requisite teaching and programmatic responsibilities) or deciding whether to take medical leave. After some deliberation, I chose not to take leave but rather to adapt my recovery needs to my responsibilities. The main reason for my decision was the anticipation of transitioning to weight-bearing with the use of a cane. I had begun to bear weight while using the walker, and use of the cane would be the next step. In retrospect, I recognized that I pushed myself to return to work before I had fully recovered in an effort to regain the routine that I associated with my former self. I found the responsibilities of my position reassuring, challenging, and exhausting. I was able to teach my courses and have good interactions with students and colleagues, but I was also aware that there were some who expressed concern about my ability to maintain my responsibilities.

## **7. Acquisition of Knowledge and Skills for Implementing One's Plan**

During my recovery period, I decided to spend some time learning about the culture of disability. My aim was to educate myself in order to improve my teaching so that my students could benefit from my enhanced understanding of the available services, benefits, and programs. I familiarized myself with the social model of disability, which views disability as a societal construct rather than a medical impairment and frames disability as a social, collective issue caused by the physical environment rather than an individual failing (Mackelprang & Salsgiver, 2016). This model rests on the principle that people are disabled by barriers in society, not by their impairment or difference. Structural barriers can be physical, such as inappropriate or inaccessible services, and another barrier includes people's attitudes, such as making assumptions about disabled people that limit their options and opportunities. I learned about the importance of practicing inclusive language, as many people who need disability benefits and services don't identify with the term "disabled," preferring the use of "people with health conditions or impairments." The importance of using positive language that respects disabled people as active individuals with control over their own lives was reinforced over and over again as a basic approach.

## **8. Provisional Trying of New Roles**

I was learning to adapt and to see my disability as a source of strength and resilience. I was open in communicating about my medical procedure, disability, and subsequent experiences to my

students. This was necessary for me to feel comfortable in my role as an instructor, especially as I worked to foster a learning community approach that valued and encouraged all voices and points of view. Students responded positively to discussing their experiences with disabilities—or “diverse-abilities,” which was a term some students preferred—which would not have otherwise been discussed. Opening the discussion allowed students to share their lived experiences, and it supported their skills to empathize in ways that could not have happened without the personal narratives.

## **9. Building Competence and Self-Confidence in New Roles and Relationship**

The necessity of using a mobility aid led me to shifts in perceptions and insights about my identity and relationships. I confronted my initial fear and negativity, and I learned to shift my attitude toward a more positive and self-affirming standpoint, thus changing the focus from disability to accessibility. I was fortunate in that I had social and professional supports that prevented isolation and sustained my competence and sense of mastery.

## **10. A Reintegration into One’s Life on the Basis of Conditions Dictated by One’s Perspective**

As my recovery progressed, I realized that I would not be perfectly “fixed,” and I accepted that, but I also became determined that my health status would not be defined by external judgments. My perspective on health is now more nuanced. I do not see health status through a binary lens of good or poor, of something one has or does not have, but rather as a continuum of abilities that fluctuate depending on both internal and external abilities, strategies, and resources. I had the opportunity of seeing my environment through the cultural lens of disability and learned first-hand about the ecosystemic impact of ableism. My perceptions and feelings were altered to make room for an identity based on resilience and adaptation to efficacious ways to navigate spaces in the world. All children and adults have the human right to grow and thrive in their environments, to use both public and private services, to take advantage of the same education and employment opportunities, and to partake in events and activities as everyone else does. I learned that disability needs to be understood from the perspective of diversity and that there is a need for disability to be addressed at the social, economic, and political levels of our society.

### **Transformative Learning about Disability**

In keeping with the final phase of reintegration into one’s life on the basis of conditions dictated by one’s perspective, I am determined to more fully integrate learning about disability and ableism into my teaching. My aim is to facilitate students’ learning about disabilities and ableism early in their social work education through theoretical knowledge and understanding; by empathizing with the challenges that persons with disabilities face; and more importantly, by gaining skills to address the ways in which the ecosystemic problem of ableism adversely affect individuals and families. Individuals and families impacted by disabilities can benefit from social work services that address clients’ concerns related to psychosocial challenges, services, programs, and mental health in competent and meaningful ways.

Dupré (2012) suggests that despite recognition of the importance of cultural and social diversity in social education and practice, social work remains entrenched in a view of disability as a problem or as a condition based on individual defects and functional limitations. I needed to experience my own disability in order to fully grasp this reality. Furthermore, Dupré (2012) asserts that there is a dearth of contemporary social work literature related to disability culture. Thus, theoretical learning and empathetic understanding related to research into practices and dominant attitudes in society that devalue and limit the potential of persons with disabilities are critical components of social work curricula. Transformative learning theory can provide an organizing framework for social work education as an approach that facilitates critical pedagogy, discussion, and reflection that can also be applied to social work practice (Jones, 2009).

### **Planning for Teaching in the Classroom**

People with disabilities are invisible in our society (Michilin & Juarez-Marazzo, 2007), and others don't usually put themselves in the shoes of those with disabilities; rather, they evaluate themselves and their environment based on their own abilities and miss the ways that people with disabilities may be excluded. Students who do not have a disability or who are not close to someone who does might not understand how the world is wired for nondisabled people and how their challenges are often invisible. Social work students need to comprehend that ableism becomes institutionalized in the beliefs, language, and practices of nondisabled people and creates systemic barriers to equitable social participation for many disabled people (McLean, 2011).

The social model of disability recognizes that disability affects every aspect of our lives, not just our health. Disability needs to be understood from the perspective of cultural diversity and must be recognized and addressed at micro, mezzo, and macro levels. As Mackelprang and Salsgiver (2016) proclaim, "We celebrate disability as an important piece of the great mosaic of diversity that makes up our society" (p. xv). Longmore found that an understanding of disability culture can provide students with a theoretical framework and insights into understanding how people with disabilities affirm and celebrate the existence of disability culture as distinguished from mainstream culture because it differentiates between negative stereotypes promulgated by the dominant culture and more positive representations of difference (as cited in Dupré, 2012).

Discussion and reflection are the mainstays of teaching in social work classrooms. These methods have also been identified as foundational to creating transformational learning. Mezirow (1991) maintains that discussion with others is integral to adult learning and development. Furthering this method, Cranton (1994) suggests that discussion guidelines ensure an atmosphere of trust, safety, and respect in the classroom in which learners can feel comfortable expressing their ideas. Guidelines that promote shared values such as respect, active listening, and participation are often explicitly stated in social work curricula and classrooms. These values also play a role in shaping reflection processes. Mezirow (1990) asserts that through reflection, individuals often arrive at "a more inclusive, differentiated, permeable and integrated perspective" (p. 14).

One of the most important elements of knowledge possessed by effective social workers is that



which comes from knowing personal values and beliefs concerning disability (Mackelprang & Salsgiver, 2016). Class discussions and reflections can be structured in large or small groups and can be guided by questions from the instructor, be based on students' own experiences and narratives, or entail a response to lecture and media materials. To encourage critical reflection, instructors may have students engage in role plays. In particular, role reversal activities help learners to explore and express views other than their own, which could encourage them to broaden their perspectives (Cranton, 1994). Another technique involves a method of journal writing in which learners use one side of the page for observations and descriptions and the other side for thoughts, feelings, related experiences, or images provoked by the description (Cranton, 1994).

The transformative learning in the classroom leads to social work practice that is informed by empathy and is ultimately based on developing resiliency as a strategy for professional use of self as well as fostering resiliency within client populations. Using the strategies of transformative learning, students will be better prepared to explore individual, family, and cultural resources that can address social conditions and barriers created by ableism. In keeping with Michilin and Juarez-Marazzo's (2007) assertion that workers need to enhance dignity and instill hope, students will be better equipped to aid clients in meaning-making about disability and its impact and meaning for the individual and family system.

All of these strategies point to the role of the instructor in creating a learning environment that is conducive to critical discussion and reflection. Teaching for transformational learning involves establishing dynamic relationships between and among learners, creating a shared body of knowledge to promote learning through various methods, and allowing for personal growth to flourish in the classroom. From this perspective, instructors not only aim toward helping students acquire key course concepts, but they also work to enhance students' personal development and attitudes toward learning (Slavitch & Zimbardo, 2012). This approach to teaching and learning is based on an atmosphere of openness, safety, and emotional support, where instructors and students have full information and are free from coercion, have equal opportunity to assume various roles, are critically reflective of assumptions, and are willing to search for common ground or a synthesis of different points of view (Cooper, n.d.).

### **Teaching Challenges**

The challenge for social work educators is to integrate transformational learning theory into their current styles of teaching. While it is consonant with a range of existing social work teaching methods focused on reflective, dialogic, and experiential approaches that foster learning, critical thinking, and empathy, it can be a challenge to manage various student responses and reactions on both objective and subjective levels. An empathic awareness can be fostered when students learn about the effects of ableist societal views and begin to contrast the conditions in their own lives with those prevailing for disabled people and their families. McLean (2011) points out that students must recognize the often discomfiting discovery of structures of privilege and disadvantage inherent in institutionalized social positions, and she uses an example of the realization that categorization as disabled is something nondisabled people do to others.

In social work education, students may experience intense emotions resulting from the recognition and awareness of the effect of personal involvement in discriminatory social practices. Instructors must allow for these types of reactions while also managing the experience for the individual and impact of the classroom as a whole. It is important to use these experiences as a teaching moment, recognizing that the affective dimension of learning also provides the substance for reflection that promotes the transformation of perspectives (Taylor, 2006).

### **Summary**

Transformative learning theory provides a useful guide to navigate unexpected challenges, such as presented in this narrative about disability. I gained new levels of perception, understanding, and action into how people with disabilities experience life on a daily basis and cope with the impact of ableism. As in life, powerful emotional responses also arise in the classroom, and these types of learning experiences have the potential to create shifts in making meaning that previously utilized ways of thinking and acting do not sufficiently explain. The phases of transformative learning define pathways to knowledge and action that have the potential to create individual and social change.

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