Southeast ADA Center
History of Disabilities Webinar
Part 1: The Tangled Roots of Disability Policy
January 11, 2018 1:00 P.M. EST

Barry Whaley:

Hi folks, I have 1:00 Eastern Time so we'll go ahead and get started. Before we do I want to share some information with you. Some of this you already heard, but these are frequently asked questions. You may be on the phone today or you may be using blackboard collaborate to listen to this session. This system makes it possible for us to conduct workshops over the Internet. Unfortunately there may be computer issues that are inherent to your system that are beyond our control. So it's important that you check your system now before we begin and our IT staff is available upon request to work with you if there's a problem prior to the start. But once this webinar begins we won't be able to troubleshoot any technical issues. This session today is being captioned. To turn on captioning please select the CC icon which is in the upper tool bar of the audio-video section. Today's session is also being recorded and will be archived for future use. And a link to that recording will be sent out to all registered participants and also will be posted on the southeast ADA website. Please share that freely with your colleagues who have missed the opportunity today to be with us.

I also want to remind you that all participant microphones and telephone lines must be muted as a courtesy to our presenter. If you do have a question, please type it in the chat area. We do welcome questions and feedback and we'll be actively monitoring that chat window and addressing questions we receive. If you want to comment on the material or if you want to share resources with our colleagues, that's great. We also have experts who are ready to answer any questions you might have in the chat area.

At this time before we begin, I suggest that if you have other applications open on your computer, you may want to close those. Because running them may interfere with your experience today. You might also want to turn off automatic systems checks that your computer does automatically to eliminate any further interference. If your computer is networked, it may

shut down if it stays idle for too long so you may want to touch your mouse or space bar to let your computer know you're still there.

My name is Barry Whaley and I'm the project director of the Southeast ADA Center based in Atlanta, Georgia. The Southeast ADA Center is a project of the Burton Blatt Institute at Syracuse University law school. We're funded by NIDILRR, the National Institute on Disability, Independent Living, and Rehabilitation Research, which is a center within the Administration for Community Living, Department of Health and Human Services. The Southeast ADA Center is one of ten centers that make up the ADA national network. Our center provides technical guidance, information, training on all aspects of the Americans with Disabilities Act. The Burton Blatt Institute at Syracuse University is a leader in efforts to advance the civic, economic and social participation of people with disabilities in a global society.

So I want to welcome you today to episode one of our four-part series of history of disability. Dr. Logue's topic today is the "Tangled Roots of Disability Policy." Dr. Logue is a senior fellow at the Burton Blatt institute. Prior to BBI Dr. Logue was a professor of history and political science at Mississippi College. His first book, *A Sermon in the Desert: Belief and Behavior in Early St. George, Utah*, was awarded the Francis and Emily Chipman Award for best first book. Since then Dr. Logue has turned his interests to the experiences of Civil War soldiers and veterans. His works include *Race, Ethnicity, and Disability: Veterans and Benefits in Post-Civil War America* authored with BBI chairman Dr. Peter Blanck, *To Appomattox and Beyond: The Civil War Soldier in War and Peace* with Ivan R. Dee, along with Michael Barton, *The Civil War Soldier: A Historical Reader*, and finally *The Civil War Veteran: A Historical Reader*. At BBI Dr. Logue collaborates with Dr. Blanck exploring the psychological trauma suffered by union army veterans. This work will lead to their new monograph in the Cambridge disability law and policy series. That monograph is entitled "Civil War Veterans' Psychological Illnesses and Suicide: Lessons from the Past". It is my honor now, distinct honor to introduce you to Dr. Larry Logue. Larry, welcome and I'll turn this over to you.

Larry Logue:

Thank you, Barry. We're going to begin our series. Since this is the beginning of it, I would like

to give you an idea of what we're going to talk about as we move along. What I have in mind is there's a -- it's not going to be a comprehensive survey, but meant to have you see some of these turning points and have you see how the story has dealt with the topic that until recently was unfamiliar with them. Also to have you see how to critique and look carefully at arguments and think critically about them. So that's what we have in mind. And with that introduction, I will start.

History of disability is full of twists and turns, many of which involve public policy. When people think about policies, they tend to turn to models of disability and models of course are sets of assumptions about what disability is and how society should respond to it. The two best known models are the ones that are usually called the medical model and the social model. This will be rehash for some of you, but I want to have us all in the same place.

To review, and introduce you to the models, the medical model assumes that disability consists of an impairment that needs to be rectified. The objective being to make people normal. The social model on the other hand contends that disability is actually a product of prejudices and exclusions and obstacles. All of which might be difficult for those that don't fit the profile for what we call normal. Some people including me wonder where these models came from. There's no quick and easy answer to this. But there are some ground rules that we can use for a start. One ground rule is that there's general agreement that the medical model came first. So we can ask a more focused question. Where did the medical model come from? To answer that, I wish I could follow Virginia Woolf, the author who wrote in or about December 1910 the human character changed. I would love to be able to say to you in 1892 the medical model was born but I can't. History is not quite that simple and the genealogy of concepts is especially problematic. We can start to explore this genealogy by calling on another -- [music playing]

Scholars presume that the medical model originated in the 19th century. The driving force behind it is thought to be increasing of physicians at the time. His authority was inspired in turn by rising general and -- such as the germ theory of disease. Under this authority, medical professionals now insisted that they could identify and remedy all sorts of conditions. So it makes sense in a way to extend this newfound confidence to disabilities. I don't plan to take issue with this consensus by medical historians, because it's true that in the late 19th and early 20th

centuries, physicians and other authorities did talk about disabilities in the same language they used when they talked about disease. Here's an example that you can see. Nathaniel Allison was a surgeon at Washington University in St. Louis. Here he is in 1915 talking about disabilities and what physicians can do. It's in our province to determine the exact status of a cripple, as they called them. His possibilities for recovery, his chances for assuming a normal place with his fellows in life. It's our province, so that means the medical profession. So to him and to his profession, disabilities were abnormalities that needed to be cured or at least improved. To allow individuals to become more normal. Normal itself was acquiring the time a meaning we give it now. Before it meant something different. Now it's becoming the standard for recovery.

All this is true enough, these things happened. But the big question remains. Were they borrowed from another time and place? The answer to that one means digging deeper. So here goes. One place to begin digging is in the early decades of the 19th century where we've been talking about the end of the 19th and early 20th centuries, we can dig deeper. That is, long before any revolution in medical authority. That may seem a stretch, it may seem too long ago to produce lasting changes. But in those decades there was a whole series of more fundamental revolutions, what one historian called a revolution in choices. Here's a sample of what happened. For one thing there was a revolution in religion revivals that began in the early 1800s and lasted through the 1830s that we call the second awakening. And you can see a dramatic picture of what these revivals were doing. In these revivals, the denominations that got the most converts were those that emphasized individual for salvation instead of Calvinist predestination. And we can see it explained in this hymn from the early 19th century. "Know that every soul is free to choose his life and what he'll be, that God will force no man to heaven, bless him with wisdom love and light, but never force the human mind." So it was individuals who bore responsibility.

In the same decades it was also a political revolution. In the 1820s, ordinary people who were more accurately men who didn't own property demanded the right to vote, whether or not they earned that property. And those demands were heeded by the 1830s. Most states gave non-property-owning males the right to vote. So elections to came to look more like this. This painting you can see is from the 1850s and it shows a pretty democratic election process. Third, there was a revolution administration of justice. Before the early 1800s, the most common punishments for crime were fines for whipping. But reformers and policy makers in the early

1800s decided on a new approach. This time they wanted to prevent crime. The new approach was the penitentiary. Whose name essentially says this is how it's supposed to work. It was supposed to be an imposing institution like this one. Where convicts can be kept in various forms of isolation, put in uniforms, made to work, made to adhere to a set schedule. This would eventually cause them -- this would eventually inspire them, I guess is the word I want -- to progress from repentance to abandonment of their criminal ways.

These are more or less public revolutions, but there were private ones too, including a revolution in childbearing. One hallmark of this revolution is a drop, a dramatic drop in the, what's shown here is the fertility index, which is technically the number of children under age 5 per thousand women of childbearing age. You can see the drop, it dropped by one-third from 1800 to 1860. Which was dramatic for any population to show. And the decline took place in cities and rural areas. So it wasn't just a matter of transition from farming to urban life. The best explanation historians have devised suggests that couples, and especially women, came to believe that childbearing was something they could actually control. Now, what do these revolutions have to do with disability? And the best answer I can give you is that it comes from a common thread that ties them together. They all appear to have a focus on individual responsibility. That is, individuals choose salvation or political leaders or law-abiding behavior, or family size. This thread is the context for another development at the time. This one involving people with mental illness.

So if individuals are the choice, the common thread is individuals, let's see how it plays out here. Before 1800, people with mental illnesses were cared for by their families or by guardians in smaller communities or confined to poor houses or jails in the larger towns and cities. But there was a major change after 1800. Medical professionals and reformers and politicians reached their own consensus. And they concluded that they could do better. Doing better meant building special institutions for those with mental illnesses. Like penitentiaries, they were meant to be imposing structures like the Illinois hospital here. Often called lunatic hospitals, insane asylums that imposed a regular routine on inmates, gave them chores where it was feasible to do so. Operating on the assumptions that, similar to the penitentiary, a mandatory regimen would repair the alleged character derangement that caused the mental illness in the first place. And would thereby allow people to recover individual responsibility they had lost. The significance of this

development shows up in this claim by an asylum superintendent in 1835. Dr. Samuel Woodward said in recent cases of insanity under judicial treatment, as large proportion of recoveries will take place as from any other acute disease. What this means is long before any medical renaissance, here's a physician claiming authority over one form of disability.

Now we have to acknowledge the limits to what all this means. Especially since these concepts were not extended to other disabilities until much later. Nonetheless, it still invites us to rethink the medical model's origins. It appears that the roots were much earlier than the end of the 19th century. And it also appears that maybe the medical model might not be an appropriate name at all. On the one hand, we can see medical involvement in the response to disability. We can see it right in front of us here. But the model's deeper foundation appears to be a revolution in individual responsibility. In fact, some scholars prefer individual model as the label, rather than medical model. Because as early as the early 19th century, authorities assumed that disability was an individual's problem, not society's. They granted that society could help with disabilities through medical intervention or institutionalization, but the goal was to change the individual, not change society.

So we should rethink the providence and the name of the medical model. And while we're at it, we need to think about another complications to our models. What I mean by that is in the late 19th century, just when the medical model is supposed to have achieved dominance, the American population who had disabilities saw an important change. The Civil War added tens of thousands of men with disabilities to that populations, and it wasn't just the numbers that were important. The types of disabilities they had were also unfamiliar. These were men with amputations and other wounds and diseases acquired in adulthood. And this means they differed in key ways from the previous population with disabilities. Now, the federal government devised policies to address these disabilities, and at first glance it appears as though the government adopted the medical model. For one thing, government provided prosthetics to amputees. Such as these. And for another, it required, at least for a while, repeat examinations for veterans who received pensions. The assumption here being that a disability that qualified for a pension might just improve.

So it looks from this angle like the medical model was firmly in control. After all, positions were

the main -- physicians were the main evaluators of veterans' disability and investment of artificial limbs and requirements for exams seemed to indicate repeat rehabilitation. I need to borrow a phrase from the world of sports. Upon further review, the appearance of the medical model is really deceptive. For one thing the artificial limb policy was mostly a failure. Given a choice, nearly 90% of union army veterans took an offer of cash rather than one of these prosthetic devices. For another thing, repeat medical exams for improvement also failed. Fewer than 5% of veterans were found to be improved enough to reduce their pension. So in the late 1870s, repeat examinations were abandoned by the pension bureau. The bureau decided on a one-time exam by a panel of physicians to verify or reject disabilities for a pension.

So the medical model doesn't fit civil war veterans very well. Does the social model fit? Not so much either. Veterans' policies do give a hint of the social model's intent to lessen the barriers against disabilities. The most prominent of these hints is an 1865 federal law that required preference for veterans with disabilities in federal jobs, and recommended preference in private employment to veterans. But the real changes from laws like this were minimal. Mostly because employment preference was overshadowed by widespread criticism of fraud and mismanagement of Union Army pensions. The most we can say is that civil war veterans stood apart from the standard models of disability. Because neither of our usual models is a good fit.

So now we can take stock of the roots we've been examining. One conclusion we can draw is that the roots went deeper than usually assumed. All the way down, all the way back to the revolutions and the individual responsibility of the early 19th century. That's where we should begin looking. For another, the roots grew slowly and unevenly. The medical or individual model applied at first to a mental illness, as we can see, but it took much longer to extend to other disabilities. Finally, this first model whether we call it individual, medical, became entangled with what we might call the military model. We might have a third one going on here. And we'll see this later on as we move through our sessions. We have to admit that the individual and medical assumptions had some effect on civil war veterans but their disabilities were mostly seen as different from those of civilians. They weren't so much defects of individuals as they were part of public responsibility that went with making war.

As I mentioned before, there were fierce debates over how that responsibility was carried out.

And the tension between military and individual and medical models carried over into the 20th century. And that will be the subject of my next presentation. Now, I've left some time for questions. The other presentations will be longer than this one. This is my shortest because I wanted to leave enough time for questions and to explore, insofar as you want to do it, these deep roots. I'll stop there and take any and all questions.

Barry Whaley:
Larry, can you see the question in the chat box? Beth is asking, "Can you talk a little bit more about the social model?

Larry Logue:
Okay. Actually, it's not in my chat box but I'll be glad to. I may have clicked the wrong thing. Here we go. Actually, the question is this: "What can you say the influence of any other cultures such as immigrant culture from Europe or Native American culture has influenced our approach?" The immigrant experience and what happened to them would be a major topic of the next session. So I'll put that one off. And Native American culture, that's a good question. And it's not clear that it influenced policy. It certainly -- the way that Native Americans treated people with disabilities was very different from what I've described. They tended to be more, I don't know, more generous. But there really isn't much influence on policy. So I'll have to kind of put this off.

Here's another question. "What specifically about the medical model led to it being eclipsed to some degree by the social model?" Ah, again. Good question and as good thinkers should do, you're anticipating what I'm going to say next. So in the next presentation, actually it will be the third presentation that we talk about -- third and fourth, that we talk about just that change. The social media's ascendancy over the medical model but for a long time it wasn't necessarily a characteristic of the medical model as it was -- what I'm going to say, I'll give you a little preview, is a more broad cultural change in American life that paved the way for the social model. But otherwise, I'll just -- that will be a teaser for the third and fourth presentations. Good questions though. I like them. Keep them coming.

"Doesn't the medical model still dominant policy?" Well, it still contributes, especially in the

medical profession's own approach to disability. But it's been at least eroded by the social model with laws like -- we'll talk about that a lot in the fourth session. It's been eroded a lot by activism that led to the Americans with Disabilities Act. So it doesn't so much dominate. It certainly contributes to policy because the medical profession has turf and they don't want to give it up. And so there's still this idea that rehabilitation is possible and that cure is possible. Okay. Excellent questions. Let me go back. Questions are coming fast. I will read as many as I can.

"Can we explore more about the individual responsibility and mass incarceration?" Well, mass incarceration is certainly predicated on individual responsibility. We don't so much -- in fact, we've kind of gone back to the initial assumption was that crime was a moral defect that could be remedied through the standard schedule lens and work. That faded and by the turn of the 20th century, these penitentiaries became essentially warehouses. In the south they were even worse. But nowadays there's more of an idea of rehabilitation. But the kind of incarceration that we have in this country still depends on ideas of moral culpability that there's something wrong with people and if they do the crime, they have to do the time. There's been a change, but it's still there.

"Did Civil War veterans receive help for psychological problems from being in combat?" That's the subject of our forthcoming back. The answer is yes and no. I'm a historian, so I seldom will give you -- I would like to give you that Virginia Woolf response but I can seldom do it. The yes part is a soldier could, a veteran could receive air pension for psychological illness for insanity if it was traceable to the war and at the end of the century they could even receive a pension for insanity if it was legitimate at all. But in terms of receiving help, no. The physicians who examined them were not supposed to provide assistance. They were just assessing conditions and reporting them. They were not supposed to treat them. So if that lies behind your question, no. Veterans -- veterans did have an institution of their own, the government hospital for the insane in Washington, D.C. and they would often be sent there if physicians thought it was necessary.

Okay. Another question. "I appreciate the idea that the term medical model may not adequately express and actually leads to some misunderstandings. I think sometimes misunderstanding leads to people to think that medical services are a bad thing." We shouldn't do that and I'm hoping that if my fourth presentation accomplishes anything, that it will deal with those kinds of things.

This isn't a competition as much as it is I guess a correction with the social model. So I'll try to make that clear as I go along with the other ones.

"Out of curiosity do you happen to have any statistics or anecdotal evidence regarding the criteria used by civil war physicians to determined disabled status?" Yes, indeed. The pension bureau put out instructions to examining physicians and they were very -- by the 1880s, they were very detailed on what constituted a disability and what didn't of the they were supposed to -- they were supposed to apply a fractional equivalent if a veteran was 50% disabled or 50% prevented from doing manual labor they would get a half pension. And the instructions were very explicit. So the answer to that one is yes. And you'll see some of that in both of our books.

"Does advancement in technology reinforce the medical model in the general psyche?" Well, yes, it does. And that goes back to what I was saying about the medical profession. They don't want to give up their authority. And I think that's the best way of putting it, and that's that authority that was originating in the 19th century. They don't want to give up that authority. As they developed technologies that are better at dealing with disabilities than they will advocate them. And the social model is kind of a corrective to that. So that's my best reading on that. Those are all the questions I have so far.

"In the early days, how did the medical field address disabled women?" Excellent. They were probably more often institutionalized than men were. And there were disabilities seen as specifically relating to women, especially ones, mental illnesses. So it's a large subject. And the medical field, when they first started out, medical men like Nathaniel Allison and especially Sam Woodward in the early 19th century believed there were specific hysteria for example -- well, but there were specific mental illnesses that were prone -- that were common to women. And so they had theories on women with disabilities. And in terms of trying to rehabilitate women or get them ready for the world of work, they didn't do so much. But still, even in institutions they segregated women and they had theories to apply to them. So that's about what we know so far.

"Did the Protestant religion view people with disabilities differently or did they generally view disabilities as personal responsibilities. Do these religions differ from Catholicism, Judaism and other religions present in the U.S. at the time?" And my best answer to that question is it's a wonderful question that needs to be explored. I haven't seen much on say the free will kinds of

denominations and how they dealt with people with disabilities and whether they thought that it was -- hindered or helped salvation. I don't know. We need some books on that topic. I haven't seen anything but I think it's a wonderful question that needs investigation. So that's often a historian's answer. We need more. Let's see if we have any other questions. I liked that last question. I think we need more on religion and disability.

Keep them coming, because those are good questions. I really like them.

"How would you relate the individual model to contemporary attitudes towards addiction and other attempts to destigmatize addiction?" Another excellent question. What I think is holding us back, holding back -- holding everybody back from addressing the issues of addiction is this idea that it does come from a moral deficiency. And I would say that that idea began in the 19th century and it's still with us. And I want to point out also that we tend to think about our era as one of unique and dramatic transformative progress and change. The 19th century may be more of a -- may have more fundamental changes. And some people have said that the basic personality structure of Americans changed in this era from tradition-directed to inner directed. People were supposed to take their cues from their own conscience. And we still have the idea, I think that maybe actuates your question, that substance abuse is an individual responsibility and a flaw in character. So well-put.

"Going back on your lecture, are there four or five factors reflected the shift to individual responsibility causes or effects of individual responsibility?" Well, there's a debate on that. The sociologist who came up with the inner-directed and other directed labels, inner-directed, tradition-directed labels, thought it was population change. Put it on to demographics. I tend to think -- I used to -- I included this in my class in American history. And I think there were a whole bunch of factors. Economic factors, such as the rise of credit and people, depending on trusting other people to pay off debts. A transportation revolution, where people could move around a lot faster and more readily. And the rise of cities. I think all those things contributed. I don't think there's a single cause to this individual responsibility rise. But and what I talked about in the presentation was of course effects. And causes? I could go on about that and they tend to be a whole bunch of causes that indicate a kind of modernization. And even in childbearing, this kind of effect was still there. The causes were complicated and the effects are many and often.

Here's another one. "You had mentioned that you cannot put a date on when the medical model began. Can you give a date when the social model began?" Ah. I wish I could. I wish I could do the same thing. Because the thing is we can see hints of it with the veterans' legislation. So it didn't bang into existence. It kind of has deep roots and we can also see it in activism by Deaf people which we'll talk a lot about in the next presentation. But there were people way back into the 19th century trying to advocate the view that disabilities are as much a product of artificial barriers as anything else. So again, I would say the roots are tangled and deep. And I would like to give a date, but I can't. Historians- which is kind of hard, because historians are supposed to be big on dates. But when we're talking about concepts, then they are a little iffier.

This is about the Protestant reformation: "What are the populations in the United States?" Well, again, we need research. We need somebody to deal with issues of the denominations and those who didn't believe. Those who were outside of organized religion. And so I don't really know. You could see- remember the introduction I gave, that we're trying to grapple with a topic that until very recently was essentially ignored by historians. So they're just now getting involved with this. And with disability as a topic of research. And here's another one. What I may do is pass on some of these questions. And see if I can get somebody to explore them. Because they're all good ones.

"How do you think the current changes in public health policy, moving towards integrated health care systems, population focused research and participatory medicine will influence our movement going forward?" Of course the trouble is that public health policy is changing. It began moving in those directions, but I'm not sure it's going to continue under the present administration. So I would say that the prognosis, prospects are mixed until there's a consensus on what public policy should be.

Barry Whaley:

    Larry, while we're waiting, I was curious in my reading of *Race, Ethnicity and Disability*, could you talk for a few minutes about the disparate treatment of African-American Civil War veterans in regard to the pension bureau and the treatment that they received in the latter half of the 19th century?

Larry Logue:

Yeah. Black veterans were much, much less likely to apply for pensions. As long as they were tied to -- as long as they had to be service connected. That is until 1890. They were less likely to apply and less likely to be approved when they did. There was clearly prejudice in the approval process and there was -- a variety of reasons why black veterans did not apply so much as white veterans. It probably was the circumstances of war because they were less likely to be wounded through their shorter period of time. After 1890 when pensions were opened up for any current disabilities, black veterans were just as likely as whites to apply. But they were still less likely to be approved. Even a difference increased. So and the same thing happened with immigrants from southern Eastern Europe. They were less likely to be approved. One of the things we speculated is this was a kind of shortcut that the pension bureau used to -- when they were swamped by hundreds of thousands of applications, it may have been one criterion they used, race and ethnicity were a criteria they used to reject pensions when there they otherwise might have approved them. So there was clear and obvious discrimination against both black veterans and veterans from southern and eastern Europe throughout the pension system. So that's essentially our findings.

Okay. Talking about the bio psycho social model. Again that's a fairly recent one and I'm going to defer to my colleagues on that one, especially Peter Blank. He would probably know a lot more about that than I do as a fairly recent phenomenon that is often applied to disability, especially to mental illness.

"Have you or your colleagues found much historical information regarding Quakers and their view of disability especially providing humane services to people with mental illness?" Well, in historical case, Quakers had a different view of the human personality that involved the inner light that people could nurture and that could make a person worthy of salvation. So I think that the, whatever research is done on religion and disbelief and other related issues, then that should include Quakers. Because they were, as your question suggested, a distinctive population. Still are, but in the 19th century, they certainly were.

Here's another question. "How is the language used around disability affected policy and its history? Is society moving more quickly in using more up to date language such as accessible,

person with disability rather than handicap, disabled and what ramifications this has with policies and government being further behind?" I think that that observation deals with what I was saying before, with the increasing -- there is a kind of revolution in tolerance that I'm going to talk about starting in the 1960s. That's when, and the language is used is, it's a really good observation on your part. Because language does reflect and shape policy. So handicapped and of course we saw a labeled of crippled. The language has suggested that society was more tolerant, is more understanding. And government being further behind? Well, that may be related to the issue I talked about before, we don't know what's going to happen with the tolerance in the current administration. So what we can say is that language changed. And I think that change reflected a real change in attitudes and whether that will continue at the highest levels, I don't know.

"Can you expand more on the government issuing prosthetics for Civil War veterans? North versus south, distribution, availability, et cetera?" The government would pay for artificial legs and artificial -- the kinds of implements you see on that slide up to a certain level. Or give a cash substitute. And the qualifications, the confederate system, what I'm talking about now is just the Union Army system. The Confederate system had its own qualifications and often provided artificial limbs independently. There's a well-known observation that Mississippi's budget included the largest item after the war was for artificial limbs. Each state in the south had its own qualifications. For the North, again, one of the biggest complaints that I've seen in looking at veterans' comments are they hated these artificial limbs. They hated the prosthetics. They thought they were terrible. And so they usually didn't go for them. But they were available. And you can see on that slide some examples. But they weren't very good and they weren't very heavily used.

"Could you talk more about the history of relationship between physical disabilities and psychological disorders? So-called visible and invisible disabilities as they relate to policy? Is it more powerful to combine or separate these two communities of policy?" I'm not sure. Nowadays I think we're more attuned, I would say, to the distinction between the two. When we get into the past, we can't be so -- I don't know, so selective. You can see I jump back and forth a little bit from mental illness to physical disability and mobility limitations. And I really don't -- I'm not totally comfortable with that. But the thing is I'm taking this with scholarship is good and revealing. So I'm sort of following the scholarship. But I'm not sure. In the 19th

century, these disabilities were certainly perceived differently and treated differently, institutionalization for some, schooling for the Deaf and so forth. So in the 19th century, people were aware and considered these. In terms of the medical and military model, any physical or mental disability could apply, deserve a pension. So the military models put them together, otherwise public policy kind of put them separately.

How many slides are there? That's the end of my slides. After this we have boiler plate things.

You're doing a good job on this one. "Can you talk about the view of people with disabilities in Civil War time?" There's a really good book, again, it focuses on one community, but it's a book on the experience of the deaf in the Civil War. And it was fascinating because I just reviewed it, it's fascinating because it talks about the various ways that deaf people had to respond to the war. Some of them joined the Army. Some of them hid their deafness as long as they could. Many of them took sides and were ardent proponents of slavery or antislavery. So I think that's the best study we have of war's effect on a population of people with disabilities. So that would be the most party would rely on the most in my answer.

"As the Individuals with Disabilities Act incorporated the idea that students should be placed in the least restrictive environment, which basically means that a student who has a disability should have the opportunity to be educated with nondisabled peers, how do these models discuss integration of persons with disabilities into the larger community if at all?" Each one does and I'm going to go back to the historical dimension of them. Each one of them talks, as we're dealing with it. The medical model wants to correct, believes that disability should be corrected so that people can resume making contribution to society. The social model wants to get rid of obstacles that allow people with disabilities to function with dignity, even if their status doesn't change. Both of them address those issues but in very different ways. It goes back to the 19th century.

"Who wrote the book about people who are deaf in the Civil War?" It was Harry Lang. Let me type it in. It's called living in the shadows. -- fighting in the shadows.

I'll stop on that one for the moment.

Barry Whaley:

Larry, I do not see any other questions coming in. So unless there are other questions for Dr. Logue today, let me remind you that this webinar series is approved by the commission on rehabilitation counselor certification for 6CRCC credits. 6 CRCC clock hours and they are approved from today until January 10th of 2019. Keep in mind that in order to get that credit, you have to attend all four either live or archived sessions of History of Disabilities and upon completion you need to request a verification from our folks at the southeast ADA center. Additionally, it's very important your feedback is always very important to us. If you would please take a minute to complete an evaluation form, found at either of the links on this slide. That would help us to look at the next three episodes and make sure we're providing exactly what you need. So the upcoming webinars are January 25, two weeks from today, will be World War I and rehabilitation. Two weeks after that on February 8th, mid-20th century ferment in disability rights and on February 22nd we conclude with civil rights to disability rights. So as you can see the topics build on each other and we can't wait for those.

I want to thank you all for being with us today. And as always, if you have questions about the Americans with Disabilities Act, you can contact either your regional center via the 800 number, which is 800-949-4232, or if you have questions or comments directly for the southeast ADA center, there is our number, 404-541-9001. Again, that's 404-541-9001. Or our e-mail, adasoutheast@syr.edu.

Thank you, Larry. Very interesting session today and thank you all who joined us. And we look forward to seeing you in two weeks. There's -- okay. Thanks everybody have a great afternoon.