

The social model of disability challenges the view of disability as an individual problem, and awareness of it can advance nursing practice

# How the social model of disability evolved

## In this article...

- › How the individual model of disability arose
- › Development of a social model
- › Using the social model in nursing care

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The way nurses conceptualise disability influences their practice. Many use an individualised model, seeing disability as an individual problem arising from activity restriction and psychological loss. However, many disabled people are critical of this approach and instead promote a social way of thinking about disability. This article presents an overview of the individual and social models of disability so nurses can increase their understanding of these approaches.

The way nurses conceptualise disability influences and determines how they care for disabled people (Scullion, 1999). Generally, nursing practice has taken an individualised approach to disability (Scullion, 2010), but many disabled people are critical of this and instead support a social way of thinking about disability (Oliver and Barnes, 2012).

### The individual model of disability

In an individual model, disability is seen as a “problem” evolving from the functional restrictions or psychological losses that arise from the disability. This underpins a “personal tragedy” approach and implies that disability is a terrible chance event, which occurs at random to unfortunate individuals (Oliver, 1996a).

Barnes et al (2010) maintained that, once a person is classified in this manner, the disability becomes their defining feature and their inability is generalised. The “solution” to their problem, then, lies in intervention by doctors and allied professionals. These “experts” apply interventions aimed at cure or rehabilitation, and define the individual’s needs and how they should be met. The aim of this medicalisation of disability is to overcome or minimise the negative consequences of the impairment (Barnes et al, 2010). It can be described as a “personal tragedy approach”, which dictates that disabled people should lead life as passive victims, dependent on family and friends, welfare benefits and services.

### Early beginnings

The origins of the individual model can be traced to the economic and social conditions that arose during the eighteenth century. As industrial capitalism developed, workforces were categorised as disabled and non-disabled (Oliver and Barnes, 1998). Disabled people were classified as a social and educational problem and many were placed in institutions (Oliver, 1990).

Prior to this period, disabled people were integrated in their communities. They had social and economic roles and, despite the variations in individual contributions and the sanctions that were often applied, disabled people were generally not excluded from family and social life (Oliver, 1990).

### The rise of institutions

During the 19th century, “Christian morality and humanitarian values” also

## 5 key points

**1** Nurses’ concepts of disability

influence and determine how they care for disabled people

**2** Nurses tend to use an individualised model of disability, focusing on impairment and loss

**3** Many disabled people prefer a social way of thinking about disability

**4** The social model redirects the focus to the disabling barriers that can be experienced by disabled people

**5** By adding a social perspective to their view of disability, nurses can help to ensure the voices of disabled people are heard



The social model promotes practices that do not silence disabled people



## “Never forget why you came into nursing and stay grounded”

Lorraine Burgess ▶ p24

had a major influence on the lives of disabled people. This included questioning the harsh treatment of people who were generally regarded as incapable of finding work. Alongside suspicions that ineligible people were claiming charity, these principles provoked an exclusionary process that differentiated disabled people from other disadvantaged community groups and placed them in the following four categories, with different treatments for each:

- » The aged and infirm;
- » The sick;
- » The insane;
- » The defectives.

The rise of institutions for disabled people, and their specialisations, coincided with the increasing dominance of the medical profession, which readily legitimised the classification between “deserving” and “undeserving” people and attributed the sick label to disabled people, putting them in medical institutions and establishing the personal tragedy approach (Oliver, 1996b).

The 20th century also saw fundamental changes in the patterns of disease and disability in modern industrialised societies. As a result of an increased focus on long-term conditions, the medical profession diversified its practice to include rehabilitation and treatment (Oliver, 1990).

Despite the contentious nature of the model, substantial gains have been made through the medicalisation of disability, with increased survival rates and prolonged life expectancy for many disabled people, as well as the eradication of some disabling conditions (Oliver, 1990).

### Classification

With regard to terminology, the individual model is associated with two classification schemas of the World Health Organization (2001; 1980): the International Classification

of Impairments, Disabilities and Handicaps (ICIDH) and the International Classification of Functioning, Disability and Health (ICF). The former was developed to clarify concepts and terminology surrounding disability to facilitate research and policy:

- » Impairment: any loss or abnormality of psychological, physiological or anatomical structure or function;
- » Disability: any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being;
- » Handicap: a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual (WHO, 1980).

These three concepts illustrated the effects of disease in terms of its impact on the body (impairment), the person (disability) and the person as a social being (handicap). The ICIDH presented a theoretical framework through which impairment, handicap and disability could be correlated (Badley, 1993). The WHO appeared to be moving away from an approach of health and disease towards a model that recognised the consequences of health-related phenomena (Bury, 2000). However, it was also widely criticised as being “unusable, confused, confusing and even disablist” (Oliver, 2009). Dissatisfaction with the ICIDH among disabled people, their organisations, and from medical researchers, resulted in the development of the ICF (Barnes and Mercer, 2003).

Unlike the ICIDH, disabled people and their organisations were involved in the development of the ICF, and the WHO (2001) emphasised it should not be misappropriated in ways that were detrimental to the interests of disabled people – particularly because it served as a basis for the assessment and measurement of disability in many health and social contexts. This included the eradication of the term “handicap”, due to its pejorative connotations in English.

In the ICF, the category of impairment was maintained but the categories of disability and handicap were replaced by the terms “activity limitations” and “participation restrictions”. They are defined as follows:

- » Activity limitations: difficulties an individual may have in executing activities – these may range from a slight to a severe deviation in terms of

quality or quantity in executing the activity in a manner or to the extent that is expected of people without the health condition;

- » Participation restrictions: problems an individual may experience in involvement in life situations – the presence of a participation restriction is determined by comparing an individual’s participation with that expected of an individual without disability in that culture or society.

In the ICF, functioning is considered an umbrella term that includes all bodily functions, activities and participation, while disability covers impairments, activity limitations and participation restrictions. A fourth dimension, contextual factors, includes the environment; it interacts with all the ICF’s constructs, allowing for individualised profiles in a variety of spheres (WHO, 2001). The ICF is described as universal because, instead of categorising only disabled people, it “covers all human functioning and treats disability as a continuum” (WHO, 2011).

Critiques of the ICF have highlighted its strengths and weaknesses (WHO, 2011; Hurst, 2000), and it remains associated with the individual model of disability (Oliver and Barnes, 2012). Many disabled people have criticised this way of thinking about disability. Indeed, Oliver (2009) observed how the individual approach dominated disability legislation and resulted in the provision of inadequate services for disabled people. Oliver (2009) concluded the changes needed in services for disabled people could only be articulated after the social model emerged.

### The social model of disability

In the social model, disability is associated with “disabling barriers and attitudes”, and the focus is redirected to “the physical, social and economic disabling barriers experienced by disabled people and the impact of anti-discrimination policies”. Further, the experience of disability does not exist solely at an individual psychological level or even in interpersonal relations, but encompasses a diverse range of social and material factors and circumstances, including family and income. The individual and collective situations of disabled people are not fixed, and the disability experience is evolving and temporal in nature. It spans the meaning of disability to individuals, the wider conditions of disabling barriers and societal attitudes, and the influences of policies and support systems.

However, the social model does not

### BOX 1. SOCIETY AS A DISABLING FORCE

● In the UK, in 1976, the social model of disability was articulated in a publication by the Union of the Physically Impaired Against Segregation and the Disability Alliance. This document gave a revolutionary definition of disability, saying the main cause of the social exclusion experienced by disabled people was not impairment but rather “the way society responded to people with impairments” (Oliver, 2009; UPIAS, 1976).

deny the significance of impairment in people's lives or the relevance of medical treatment to the experience of impairment. Instead, it highlights the indifference by advocates of the individual model to the existence or influences of disabling social and environmental barriers (Barnes and Mercer, 2006).

### The disability rights movement

In Europe and North America, during the 1970s and 1980s, disabled people and their organisations became increasingly dismissive of the individual model. In the UK, the Union of the Physically Impaired Against Segregation (UPIAS), among other organisations, called for an alternative approach (Barnes et al, 2010) (Box 1).

Barnes et al (1999) observed how, during the economic and political crises of this period, the reformation of the British welfare state hit disabled people hard, inadvertently leading to the politicisation of disability, and the generation of a disabled people's movement.

The social model "became the central concept around which disabled people began to interpret their own experiences and organise their own political movement" (Oliver, 1996b). It shifted "attention to disabled people's common experiences of oppression and exclusion and those areas that might be changed by collective political action and social change" (Oliver and Barnes, 2012).

By the 1990s, it had been adopted by the state and professionals, and was being colonised by a range of organisations, interests and individuals, some of whom had bitterly opposed its appearance less than 10 years previously" (Oliver, 2009).

### Origins and terminology

UPIAS (1975) questioned the role of professionals in the lives of disabled people and emphasised "the imperative need for disabled people to become their own experts". It broadly accepted the ICIDH definition of impairment (Oliver and Barnes, 1998), but offered the following terms:

- » Impairment: lacking part or all of a limb, or having a defective limb or organ or mechanism of the body;
- » Disability: the disadvantage or restriction of activity caused by a contemporary social organisation that takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities (UPIAS, 1976).

Subsequent discussions with other organisations of disabled people have

broadened this terminology and its reference to "physical impairments". Now any impairment can be embraced in the scope of disability, including those that are sensory or intellectual (Barnes et al, 2010).

### Supporters and critics

Criticisms of the social model's conceptual and practical application have been raised from within and beyond the disabled people's movement and disability studies, with supporters and critics discussing at length major areas for consideration (Barnes and Mercer, 2010). These include the following:

- » Its inability to deal effectively with the realities of impairment (Oliver, 2009);
- » Its inability to integrate other social divisions (Oliver, 2009);
- » The issue of "otherness" (Oliver, 2009) – the manner in which cultural values locate disabled people as "other" (Shakespeare, 1994).

Critics have also called for the social model to be abandoned in favour of a more adequate approach to disability politics (Shakespeare and Watson, 2002).

### Conclusion

The social model is not without its critics, but it offers nurses a way of thinking about disability that can promote nursing practices which do not silence disabled people. However, nurses must ensure their practice remains reflective and self-critical and that they are informed by the social model rather than forcing it on people's experiences – particularly because not all people labelled so regard themselves as disabled, or are aware or supportive of this approach. Nurses should not impose the social model with unrealistic expectations (Box 2), but they can trust its efficacy in assisting them with the continued politicisation of disabled people. **NT**

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## BOX 2. THE SOCIAL MODEL OF DISABILITY

● "The social model is not about showing that every dysfunction in our bodies can be compensated for by a gadget, or good design, so that everybody can work an eight-hour day and play badminton in the evenings. It's a way of demonstrating that everyone – even someone who has no movement, no sensory function and who is going to die tomorrow – has the right to a certain standard of living and to be treated with respect" (Vasey, 1992).

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