**PERSONS WITH DISABILITIES**

The philosophy of rehabilitation begins with a belief in the dignity and worth of all people.

* The terms and language used in practice must reflect and reinforce this belief, as well.
* Rehabilitation practitioners use differing terms when referring to those individuals seeking services. Medical professionals refer to their “patients” and educators to their “students”; legal and mental health professionals refer to their “clients.”
	+ Traditionally, the term client has predominated in the rehabilitation counseling profession and its practice. However, the terms consumer or customer have been advocated as the preference among some persons within disability communities, because these terms are believed to reflect a more empowered status for persons with disabilities in relation to their service delivery systems and professionals.
	+ The terminology used may be a sensitive issue for some persons: Asking each person about their preferred terminology is always appropriate.
	+ The terms client and consumer are used respectfully, yet interchangeably when referring to persons who seek or receive rehabilitation services.
	+ In addition to the terms used in spoken reference to persons with disability, one must be aware of, and to comply with, similar principles concerning written communication.

 The guiding principle always is to use language that maintains the integrity and dignity of people as human beings. When communicating orally or in writing, the APA (2001) guidelines suggest the following rules concerning reference to disabilities:

• Put peoples first, not their disability. Preferred expressions avoid the implication that the person as a whole is disabled.

• Do not label people by their disability or overextend its severity. Because the person is not the disability, the two concepts should be separate.

• Use emotionally neutral expressions. Terms such as victim, afflicted, suffering, and confined are examples of problematic expressions that have excessive, negative overtones and suggest continued helplessness. To this end, language should be avoided that (a) equates persons with their condition (e.g., “the disabled” or “epileptics”), (b) has negative or superfluous overtones (e.g., “AIDS victim”), or (c) is regarded as a slur (e.g., “cripple”).

* Consistent with the conceptual framework of practice, use of the term disability should occur only to describe an attribute of a person, and handicap to describe the source of limitations, such as attitudinal, legal, and architectural barriers.
* Disability and handicap are not synonymous. In addition, the terms challenged and special are often considered euphemistic and should be used only if the people you serve prefer them.
* The term of the professional’s reference, be it client or consumer, as well as the language used to describe a person involved in rehabilitation services, is a critical consideration.
	+ Some persons with disabilities may choose other language conventions. For example, some members of the deaf community prefer to be referred to collectively as “the deaf” or individually as “a deaf person.” This language preference is also found among some members within the blind community.
	+ Avoid the use of the term normal in any way. As professionals working with persons with and without disabilities, we must communicate clearly and respectfully. An open discussion with the person with whom you are working usually provides a forum for selecting language to be used subsequently with each individual.
	+ The language chosen communicates a philosophical and attitudinal orientation at both a personal and professional level.

DEFINITIONS OF DISABILITY

* The rehabilitation counselor must be sensitive to the existence of various definitions of disability, their varied uses, and the relationships among them.
* These definitions are used to define eligibility for programs and services. For example, for a person to be protected by the Americans with Disabilities Act (ADA, 1990), the law specifically defines an individual with a disability as a person who: (1) has a physical or mental impairment that substantially limits one or more of the major life activities of that person, (2) has a record of such an impairment, or (3) is regarded as having such an impairment.
* An individual must have a disability that causes major problems in getting, preparing for, or keeping a job, and that requires VR services to be able to work.

, “Policy and Law,” provides an in-depth understanding the definitions of disability from these various points of reference is critical for the rehabilitation counselor, in order to effectively provide for the total rehabilitation of their clients.

PARADIGMS OF REHABILITATION PRACTICE

* Rehabilitation counseling is different from the other helping disciplines involved in rehabilitation, such as medicine or psychology. This system of categories considers rehabilitation from the perspective of primary, secondary, and tertiary prevention of disability:

• Primary prevention is characterized by the provision of interventions directed toward preventing the onset of disease or disability. Professionals from such fields as public health and occupational health and safety have traditionally provided primary prevention.

• Secondary prevention is characterized by the provision of interventions directed toward preventing or, when that is not possible, limiting the effects of the disease or disability in persons, when primary prevention has failed. Professionals from medicine, psychology, and similar curative fields have traditionally provided this level of prevention.

• Tertiary prevention is characterized by activities directed toward preventing long-term residual conditions from having any greater disabling effects than necessary, once the secondary prevention fields have done all they can do to cure or limit the disease/disabling process. Professionals from rehabilitation counseling and allied fields have traditionally provided tertiary prevention.

* The attention given to the individual and to the environment differs at each level.
	+ Primary prevention, for example, is heavily weighted toward the environment (e.g., drinking water supply, work site safety, automobile seat belts) and considers individuals only insofar as that environment affects them.
	+ Secondary prevention is heavily weighted toward the individual (e.g., curing or limiting the pathology that exists within the individual) and examines the environment only insofar as it facilitates or impedes the curative process within the individual.
	+ Tertiary prevention differs from both of the other categories of prevention, in that it requires an equally balanced focus on both the environment and the individual. This dual focus is necessary, because disability may stem as much from environmental barriers as from individual limitations. Rehabilitation as a tertiary intervention can be viewed as a process of addressing specific goals with therapeutic interventions.
* The tripartite model of intervention identifies three phases or components of rehabilitation intervention. Embedded within the broader model of therapeutic interventions, these three components are 1) disability minimization, as an effort to reduce its impact upon life activities; 2) skill development, as an attempt to compensate for limitations caused by permanent losses; and 3) environmental manipulations to promote physical, psychosocial, and social attitudinal accessibility.
	+ The paradigms derived from the three categories of prevention provide a basis for understanding and distinguishing the roles of the multiple disciplines that are part of the interdisciplinary rehabilitation process. Each level is represented by a discipline such as public health, medicine/ psychology, and rehabilitation counseling. Each discipline and each level is different from the others in its basic science, focus, strategy for intervention, and goals. All disciplines have a unique and important contribution to make in the rehabilitation endeavor.

PARADIGMS FOR REHABILITATION COUNSELING

For intentional, systematic practice to occur, rehabilitation counselors must have a conceptual model or paradigm to guide their work. It has been suggested that rehabilitation counselors have at least three orientations from which to conceptualize their teaching, research, and practice.

* These paradigms include the psychomedical model, the systems model, and the ecological model.
	+ Each of these orientations has merit and distinguishes itself by the relative emphasis it places on the person, the environment, and the relationship between the two.

The Psychomedical Model

The psychomedical model looks within the individual for a diagnosis of the problem, placing the person in a one-down position, relative to the expert, typically a physician or psychiatrist.

* From this perspective, the person with a disability is considered a patient. The psychomedical model represents a biomedical orientation toward the scientific representation of the person’s condition and uses diagnostic categories to administratively classify and subsequently treat the underlying cause of a person’s disability.
* This approach is valuable for understanding the medical and allied health professional’s contribution to the rehabilitation team. It underlies the restorative services offered in rehabilitation and is related to the secondary prevention model referred to earlier.

The Systems Model

* This perspective suggests that neither the person nor the environment is the unit of analysis. The unit of analysis is in fact the relationship between the two. This perspective also suggests that focus on either the individual (psychomedical) or the individual–environment transaction(ecological)is inadequate, because the inherent nature of persons is systematic.
	+ Disability impacts all persons with a relationship to the person with disability. Focusing on and understanding these relationships with others in those environments in which persons with disabilities live, learn, work, and recreate are critical to this point of view.
	+ This perspective argues for the inclusion of family counseling and systems training in the curriculum for the development of competency in the rehabilitation counselor.

The Ecological Model of Rehabilitation Counseling

The Ecological Model of Rehabilitation Counseling proposed herein reflects a tertiary prevention model, with equal consideration being given to the person and to the environment.

* This approach represents an alternative to the psychomedical and systemic models. Historically, the ecological perspective on rehabilitation has emerged from a trait–factor tradition, which measures traits within the individual, as well as factors within the environment. An evaluation is then made to determine the extent of match or congruence between traits and factors.
* Decisions about the probable success of a person placed in a vocational, independent living, or other environment would then be made, based on this information.
* Empowered clients make meaning out of their experiences. They take responsibility and ownership for their decisions, given their increased awareness about their strengths and the demands of the options they are considering.
* An ecological perspective, with a developmental orientation, transformed a trait–factor approach into a viable theoretical framework for VR.
* Basically, this Ecological Model, in consideration of individual traits and environmental factors, provides a conceptual infrastructure for the profession of rehabilitation counseling and its model of practice.
* Both traits and factors can be measured or assigned numbers, to indicate the extent to which each is present in the individual and the environment. To better understand this Model, this approach is briefly described.
* ***Traits*** refer to the underlying characteristics that exist in people. Traits account for the observed behavioral consistencies within people and for the stable and enduring differences among people. All people are assumed to possess the same traits, but in differing amounts (typical performance and maximum performance).
* In the process of measuring the traits of an individual, the rehabilitation counselor must infer their presence from samples of behavior, because traits cannot generally be measured directly, other than physical traits such as range of motion. The particular traits that the rehabilitation counselor decides to evaluate will depend on the purpose of the assessment.
* Traits indicative of typical performance describe how a person typically behaves in situations. The behavioral consistency principle is applied here, with the assumption being made that past performance is the best indicator of future behavior.
	+ These traits include the individual’s interests, temperaments, values, and other indicators of personality. The typical behaviors are evaluated through interview, observation, and the occasional use of inventories, in other words, through the use of expressed, manifest, and test strategies.
	+ Evaluating these traits, and comparing their correspondence with potential environments, facilitates making more accurate predictions regarding a client’s probable satisfaction with the factors present in various environments.
	+ The rehabilitation counselor may predict with enhanced accuracy the person’s likelihood to remain in a particular environment, by evaluating this satisfaction.
	+ The factors against which a person’s typical behavior traits are evaluated include environmental reinforces, such as salary, advancement possibilities, and position prestige, as well as other social and interpersonal factors. Therefore, identifying the client’s needs, interests, and personality is critical, as well as the reinforces and the social/interpersonal factors that are present in environments under consideration.
	+ The extent to which factors meet specific needs will provide important data to the client for decision making. Traits indicative of maximum performance describe a person’s capacities and capabilities. These traits include physical capacity, aptitude and achievement, and other indicators of ability.
	+ The maximum behaviors are evaluated through test, manifest, and expressed strategies. Evaluating these traits facilitates making more accurate predictions regarding the satisfactoriness of a person’s capacity to perform the essential functions and tasks required in education, employment, independent living, and other major life activities.
	+ The matching or congruence between the client’s performance and the job or task has been described as the “level of satisfactoriness.”
	+ The factors against which a person’s maximum behavior traits are evaluated include the environment’s essential and marginal functions, including physical, educational, and skill demands.
	+ In evaluating persons’ traits, equal consideration must be made for what they want to do (typical behavior) and what they are capable of doing (maximum behaviors).
	+ Therefore, considering the person’s interests and the environment’s ability to meet these needs is critical, as is their ability to perform essential functions in the environment, in order to enhance their tenure in a given job.
	+ Although, in some instances, psychologists and other professionals may be involved in this rehabilitation assessment and information gathering process, rehabilitation counselors themselves may secure this information through interview, observation, and the occasional use of inventories.
	+ The question of who secures what information is a matter of each individual professional’s scope of practice and of the available resources that define the functions performed by the staff in a particular human service or rehabilitation system.

ECOLOGICAL ADAPTATION MODEL

The Ecological Model of Rehabilitation Counseling provides a framework for counselor practice and client decision making. This trait–factor approach does not address the psychosocial adaptation of persons with their disabilities. The rehabilitation counselor must also have a framework within which to consider the psychosocial impact of disability.

the Ecological Adaptation Model, which conceptualizes this reciprocal relationship, as (1) the nature of the individual with a disability as they interact and to various degrees adapt to various environments, and (2) the simultaneous ability of environments to accommodate persons with disability. This model highlights the importance of not only assessing traits and factors, but also the transactions that dynamically describe the interactive nature of person(s) and their environment(s).

* Counselors need to be aware of the differing requirements of each rehabilitation system providing services.

THE REHABILITATION CONCEPT

Once the rehabilitation counselor has a clear respect for and understanding of the philosophy of rehabilitation, the concept of disability, their own role and scope of practice, and a systematic paradigm to guide that practice, it is possible to revisit and further describe the rehabilitation concept. Maki (1986) operationalized the rehabilitation philosophy, defining the rehabilitation concept in terms of a comprehensive, Individualized process, prescriptive in nature and directed toward the development or restoration of functional independence and QOL.

Traditionally, VR defines functional independence in terms of economic self-sufficiency; independent living rehabilitation defines it in terms of community integration and autonomous living. Both VR and independent living rehabilitation programs increasingly include QOL indices in their definitions of successful outcome.

The following represent the key elements in understanding the concept of rehabilitation:

• It is comprehensive in scope and holistic in nature. The rehabilitation process is an orderly sequence of activities related to the total needs of the individual.

* Although comprehensive services will differ from client to client, certain basic dimensions are relevant to understanding the total person.
* The most significant dimensions include the medical, psychological, personal–social, cultural, educational, vocational, and spiritual.
* To understand the client or to provide services relating to only one dimension of the person’s life functioning, without considering the other aspects and their interdependency, would be ineffective and could result in the ultimate failure of the rehabilitation effort.
* Effective rehabilitation thus often demands the coordinated efforts of a multidisciplinary or interdisciplinary team. The rehabilitation counselor is an integral member of this team.

• It is an individualized process. Each person is unique in terms of skills, residual capacities, functional limitations, resources, and personality. The manifestations of disability present themselves differently in each individual, with varying meanings and implications for rehabilitation, depending on the environmental context.

* Rehabilitation is considered a process based on the needs and assets of each individual client. Rehabilitation counselors must continually be aware of the pitfalls of labeling and stereotyping.

 • It is prescriptive in nature. That is to say, a prescriptive course of action is developed with each individual. The type and number of services provided are based on the needs and characteristics of the individual. The services are selected that will remove, reduce, or compensate for the functional and societal limitations of the individual, so that they can achieve the goals established in the individualized plan. Environmental accommodations and modifications must be considered, as well as client development and adaptation.

• It functions to develop or restore. Habilitation is the term denoting the development or acquisition of skills and functions previously not attained. This term is used commonly to refer to the service of persons with disabilities who, because of lack of training or experience, are initially developing their functional independence. Habilitation refers to an initial learning of skills and roles that allow an individual to function in society.

* Rehabilitation refers to the restoration or reacquisition of skills and functions lost through injury, disease, or trauma;

 • Its goal is functional independence and a QOL. Functional independence is the capacity of individuals to take care of their affairs to the extent that they are capable. Functional independence is a broad goal:

Subsumed under the goal are economic self-sufficiency, as well as personal, social, and community living skills. It also reflects the individualized nature of the definition of success and functioning. Functional independence considers the total individual in all their environments.

A QOL perspective on rehabilitation counseling integrates competing program goals, such as client independence or employment, into a higher order, multidimensional rehabilitation outcome. Counselors committed to a QOL orientation work from a wellness and holistic position, which addresses both the development and adaptation of the individual and the accommodations that environments can achieve, where the person lives, learns, works, and recreates.

* QOL is directly applicable to the longstanding question of how to define successful outcomes in rehabilitation. Rehabilitation professionals continue to disagree about whether the primary goal of rehabilitation is promoting client independence or vocational placement.
* QOL offers a higher-order goal that subsumes both independence and employment as legitimate outcomes.

THE REHABILITATION PROCESS AND COUNSELOR FUNCTIONS

Historically, persons with disabilities have received services through a delivery system containing the following ordered components:

* Intake, assessment, services, and outcomes. This generic model accommodates the interdisciplinary nature of rehabilitation.
* No matter where or what other functions and responsibilities are engaged in by the rehabilitation counselor, counseling is the central function that is provided continuously throughout the rehabilitation process.
* Counseling is a nontransferable obligation of the rehabilitation counselor. Consultant and rehabilitation services of other kinds may or should be purchased, but the ultimate professional responsibility for the function of counseling cannot be delegated. Professional counseling is indispensable to the proper selection, provision, and utilization of the other rehabilitation services.

Services provided by the rehabilitation counselor directed toward the environment are consultation and advocacy, when those environments and persons in the mare relevant to the success of the client’s plan.

* Consultation is a function through which the counselor engages in “the process of environmental restructuring and requires consultation with the client’s family, employer, and community”.
* The key skills, knowledge, and ethical and professional issues relevant to consultation by rehabilitation counselors.
* Consultation is frequently interdisciplinary, with the consultant either being internal to the organization or external from it.
	+ External consultants are more often readily viewed as experts, but may lack important background information that would be more accessible to an internal consultant.
	+ Consultation may occur as expert consultation or process consultation.
* In expert consultation, the consultant is responsible for the design, implementation, and success of the intervention. In process consultation, the consultant works in active partnership with the consultee, to design and implement change. Here the success of the intervention is shared between the consultant and the consultee.
* Consultation may focus on primary, secondary, or tertiary prevention. Each of these foci may be targeted to individuals, groups, organizations, or communities.
	+ Primary prevention consultation focuses on such areas as enhanced communication, decision making, and coping.
	+ Secondary prevention consultation occurs in areas such as job-enrichment programs or remediation of learning disabilities.
	+ Tertiary prevention focuses on reducing the impact of functional limitations

**Models of Disability:**

**The Juxtaposition of Biology and Social Construction**

One way to conceptualize the experience of disability is to examine the various models of disability.

* “A model is a set of guiding assumptions, concerns, and propositions about the nature of phenomena or human experience. Models have often been defined as human-made tools for understanding and human-made guidelines for action”.
* In addition, models provide definitions of important human constructs and attritional explanations for both causation and solution.
* In short, models provide a window to our understanding of disability.

The three major models of disability:

The biomedical model,

The economic model, and

The sociopolitical model

PURPOSES OF MODELS OF DISABILITY

Models of Disability Provide Definitions of Disability

If the concept of disability cannot be defined, there can be no discussion about ways to respond to disability. All three models ask the questions, What is a disability? and Who has a disability?

* Each of the three models answers these questions differently, and each model reduces the concept of disability to a single, narrow quality. Therefore, no single model has the capability to completely capture, explain, or describe the disability experience.
* In addition, no one diagnosis or classification system can represent the complete experience of having a disability.
	+ Further, definitions of disability vary with the purposes, values, and needs, and also the intellectual discipline, of the definers. Zola’s (1993) article, “Disability Statistics, What We Count and What It Tells Us,” provides an excellent introduction to the varying definitions of disability and to the relationship between the values of the definers and the definitions they provide. (Zola, I. K. (1993). Disability statistics, what we count and what it tells us. *Journal of Disability Policy Studies*, 4, 9–39.).
* Models provide definitions, which result in labels (and, often, stereotypes), and these labels have profound power over the individuals who carry these designations. Clinical, legal, administrative, cultural, and personal definitions of disability evolve from these models
* Generally, many of the underlying concepts in the definition(s) of disability are only invented human assumptions.

**Models of Disability Provide Explanations of Causal Attribution and Responsibility Attributions**

* In order to begin constructing a model of disability, determining the location of the problem is necessary.
	+ Causal attribution refers to the explanation and understanding of the cause or source of the disability, and
	+ responsibility attribution refers to the assignment of responsibility for the response to the disability.
	+ In other words, attributional theory asks (and attempts to answer) these questions: Who is responsible for the disability? And Who is responsible for the solution? or What, if anything, should be the responsibility of society toward individuals with disabilities? Or, Who benefits? and Who pays?
* In the biomedical model, for instance, the individual considered to be responsible for the problem is thought to also be held responsible for the solution. Presently, however, there is a trend toward disregarding causal attribution altogether and focusing solely on solution attribution.
	+ Casual attribution (in models of disability) has three inherent difficulties:
		- First, causes of disability are not very well understood; such causes are not easily measured, and they often defy classification. Frequently, the cause of disability is not known, or there are many causes (such as several forms of mental illness), or theories about causation may change.
		- Second, who is responsible for etiology of disability is often assumed to be a single individual—typically, the individual with the disability—rather than institutional causes, such as poverty, dangerous workplaces, or lack of insurance coverage.
		- Third, determining the cause of a disability asks the question, How? However, often, this is distorted to ask the question, Why did this disability happen?
* Science and medicine can attempt to answer the “how” question, but these professionals do not and cannot answer the “why” question; indeed, no one, in any field of expertise, can definitively state why a disability occurs.

Finally, the rationale underlying causal and responsibility attribution is to gain understanding and explanation and to formulate accountability guidelines.

* + However, casual explanation may be distorted to become fault, blame, and moral accountability placed upon the individual with the disability.

**Models of Disability Are Based on (Perceived) Needs**

If the presence of needs is established and recognized, then ways in which to meet these needs can be implemented.

* First, however, these needs must be clearly defined. Each of these three models of disability outlines the needs of people with disabilities in a single, narrow dimension.
	+ In the biomedical model, the needs are viewed as medical, and, accordingly, resources are marshaled to meet medical needs; in the economic model, needs are thought to be economic and vocational; and, in the sociopolitical model, the needs of people with disabilities are considered to be full social integration and equal political rights.

**Models Guide the Formulation and Implementation of Policy**

The history of each of these models can be easily traced, including resulting policies, laws, and public attitudes.

* Legislation and policy both reflect and affect society’s values and perceptions. Because a model defines and describes the needs of people with disabilities, the natural outcome is the formulation of policies into practice.
* Similarly, if the model used determines the location of the problem, then collective publication will attempt to solve the problem. For example, in general terms, much of workers’ compensation law is the result of the medical model of disability; the state–federal vocational rehabilitation (VR) system is the result of the economic model of disability; and the Americans with Disabilities Act (ADA) is based upon principles of the sociopolitical model of disability. As can be seen from the preceding examples of legislation and governmental agencies, there have been no comprehensive and unified disability policy in the United States. This lack of a clear focus can be traced to the use of differing models of disability.

**Models of Disability Are Not Value Neutral**

* reflect the needs and values of those who construct the models.
	+ There is no value-neutral language with which to describe disability. Two of these models (the biomedical model and the economic model) have their origins in religious value systems.
	+ Further, formalized collective definitions and policies are crystallized in legislation. Those in power construct models, including definitions and diagnoses, then devise and implement policies and laws based on these models.
	+ People have had the power and resources to define disability and to determine the types of services (if any) that people with disabilities receive.
		- Powerful people, most often those without disabilities, defined the disability experience and developed the mechanisms with which to respond. For example, much of the legal disenfranchisement and marginalization of people with disabilities have been legalized and enforced by adherence to and belief in the biomedical model of disability, although the general public often assumes that clinical definitions are neutral. Nonetheless, all three models of disability are neither reality nor objective.

**Models of Disability Determine Which Academic Disciplines Study and Learn About People with Disabilities**

* In the past, disability was thought to be solely a medical and biological phenomenon, and therefore only medical schools taught about disabilities. Because disability was not viewed as a social concern or responsibility, few disability issues were taught in the social sciences, such as psychology, sociology, or social work. People with disabilities were (and are) invisible in most college and university courses. Therefore, professionals graduated unaware, or falsely assuming, that they would not provide services for people with disabilities. As models of disability evolve, the number of people with disabilities increases, and individuals with disabilities develop stronger advocacy systems, the curriculum of professional developments and preparation programs will begin to include information about the disability experience.

**Models of Disability Shape the Self-Identity of People with Disabilities**

* Models provide labels, diagnoses, and theories of causation and responsibility, all based upon(seemingly)authoritative and prestigious sources. These beliefs are widely held, strongly believed, and constantly socially reinforced. Because these beliefs are pervasive and widespread, many individuals with disabilities have adopted these beliefs as self-identifiers.
* Simply because they have heard these stereotypes so often and also because people with disabilities frequently lack role models with disabilities, people with disabilities accept these stereotypes as truth about themselves. Society, therefore, has effectively taught many people with disabilities to feel inferior and dependent.

**Models of Disability Can Cause Prejudice and Discrimination**

* Models of disability are not harmless abstractions or theories (they are abstractions and theories, but they are not harmless).
	+ Rather, models of disability guide public attitudes, shape legislation, determine the services provided, and influence the training of professionals, all of which can create prejudice and discrimination.
	+ In addition, models of disability have a significant impact on how (or if) people with disabilities are portrayed in the mass media.
	+ With a normative emphasis, disability is thought to be inequality or deviance from a valued norm or standard. If a model of disability has a normative element, prejudice, discrimination, marginalization, and reduced opportunity will result.
* Two of the models of disability consider the absence of disability to be the desired state and, conversely, view the presence of a disability as undesirable deviance.
	+ Indeed, the search for the origins of prejudicial attitudes leads back to these models of disability. Further, much of the prejudice and discrimination may not appear (to those without disabilities) to be prejudicial or unwarranted, simply because these models of disability have had long histories, and two of these models have the support, authority, and prestige of the established disciplines of science (biology and economics).

**RESULTS OF MODELS**

* After revising the basic components and functions of models of disability, two issues should become apparent:
	+ First, models of disability, although abstractions, result in the daily, lived experience of people of disabilities. The services people with disabilities receive, their social integration—indeed, all aspects of the lives of people with disabilities—are influenced by the model(s) of disability one accepts.
	+ Second, both the experience of having a disability and the experience of responding to people with disabilities are not wholly biological in nature, but are also social and cultural constructions. Examining the ways in which we describe and understand the world around us, including the people in it, is important. Occasionally, our understandings can be flawed or incomplete. Nonetheless, it is essential to be clear about the model of disability in use, including its shortcomings; therefore, we now briefly review the three main models of disability (biomedical, economic, and sociopolitical).
* Disability scholars have posited other models of disability, but the three presented here are considered to be the most common. Also, these models are occasionally labeled differently; for example, the biomedical model is also termed the ***disease model***, the economic model is sometimes referred to as the ***functional model***, and occasionally the sociopolitical model is termed the **minority group** paradigm.

**THE BIOMEDICAL MODEL OF DISABILITY OR A PERFECT WORLD IS A WORLD WITHOUT DISABILITIES**

* Of the three models discussed, the biomedical model has the longest history: This model has been in use for centuries. Bickenbach (1993) defined the biomedical model of disability:

The most commonly held belief about (this model of) disablement is that it involves a defect, deficiency, dysfunctional, abnormality, failing or medical “problem” that is located within the individual. We think it is so obvious as to be beyond serious dispute that disablement is a characteristic of a defective person, someone who is functionally limited or anatomically abnormal, diseased, pathoanatomical, someone who is neither whole or healthy, fit or flourishing, someone who is biologically inferior or subnormal. The essence of disablement, in this view, is that there is something wrong with people with disabilities.)

* There are two important components of this model.
	+ First, pathology must be present, and
	+ Second, the pathology is located within the individual.
* Disability is not viewed as a valued difference, but as deviance from a desired normality or standard of evaluation.
* Further, disabilities are treated as objective conditions that exist in and of themselves. Certainly, the degree of societal stigma toward an individual’s type of disability is never considered when clinicians determine the disability’s level of severity. According to the biomedical model, people with disabilities, as victims of misfortune, should be grateful for any sympathy, pity, and charity that might be offered.
* Taken further, their “personal tragedy or flaw” (the disability) relieves society of the responsibility of according full civil rights to people with disabilities.
	+ The biomedical model is not considered to be interactional, because the problem of disability exists entirely within the individual. Therefore, society tells people with disabilities, “This is how the world is. Take it or leave it.” It is the person with a disability and their aspirations which must be modified.
	+ In order to establish the presence of a disability (or pathology), diagnostic testing and assessment are necessary.
	+ In addition, diagnostic classification systems, such as the International Classification of Impairment and Disabilities and Handicaps (ICIDH) and The International Classification of Functioning, Disability, and Health (ICF) (World Health Organization [WHO], 1980, 2001) and the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM–IV–TR) (American Psychiatric Association, 2000) must be constructed.
	+ Therefore, diagnoses and other medical labels are only as good as the diagnostic tools, tests, instruments, and classification systems used.
	+ Many scholars argue that these tools and systems are flawed: “Diagnostic categories and classification schemes are acts of the imagination rather than real things in the world. . . . We must not mistake this for reality itself”.
	+ Some questioned these systems (terming them “false precision”) and stated that diagnosis are not the product of “a scientific procedure of unquestionable validity, free from error.”
	+ Also they considered diagnoses as “an unattainable quest for neutrality,” simply because a physician (who is a person) renders the diagnosis. Therefore, medical diagnoses can be subjective, impressionistic, value-laden judgments of individuals.
		- Medical diagnoses are becoming more standardized, and, also, disability ratings are becoming more numerical in nature. Nonetheless, both still remain subjective and incomplete.
		- For example, VR counselors are well aware that two individuals with the same medical diagnosis and identical numerical ratings of severity of disability will have very different outcomes.
		- Clinicians have attempted to include environmental issues in their classification systems. For example, in 1980, the WHO clearly differentiated among impairments, disabilities, and handicaps, and, indeed, the ICIDH is organized around these three concepts.
			* + Essentially, impairments were defined as purely medical phenomena;
				+ disabilities were defined as the inability to perform socially valued roles, and
				+ handicaps were defined as obstacles in the environment.
* Twenty years later, the shortcomings of previous editions of the ICIDH were addressed. Certainly, much clearer and more precise distinctions are made among the individual’s disability, level of functioning, and environment. Indeed, the ICF as “a classification system of human functioning” focuses on health and adaptive functioning, rather than on pathology and dysfunction.
* In spite of these recent changes to the ICF, it remains a classification system utilized by professionals. Diagnoses of disability also excuse society of the need to value people with disabilities.
	+ There is a normative foundation to the biomedical model, in that the prevailing picture of normal or typical human kind is of people without disabilities.
	+ The conception/definition of normality is often viewed as an exercise in wordplay. However, the concept of normality has guided the development of the built environment.
		- Physical environments are constructed for “normal” people. The absence of accommodations, lack of accessibility, and prejudice and discrimination are not noticed by those who have been designated as normal.
		- Even more important, the absence of people with disabilities in society is often not noticed. Not only does the built environment prevent people with disabilities from full participation, but people without disabilities are not aware of this segregation imposed upon people with disabilities.
		- One disability scholar (Higgins, 1992) has termed this as making people with disabilities “foreigners” in their own country, educating and housing, and employing them in separate (and often inferior) environments.
		- Every individual with a disability, regardless of their privilege, economic resources, education, or achievements, knows that they belong to a devalued group, and many individuals with disabilities (especially the Deaf) feel there is nothing to be gained by trying to assimilate into society that devalues them.
		- Indeed, the biomedical model considers people with disabilities to be people who have adjustments and adaptations to make.
			* A perfect world, according to the biomedical model, is a world without disabilities. Disabilities are to be prevented. At the extreme, this can be distorted to mean that people who have disabilities should be eliminated.
			* The biomedical model can be interpreted as categorical devaluation. Clinicians and medical practitioners understand that the diagnoses they render describe a condition that an individual experiences and not the individual himself or herself; however, there is a tendency to treat individuals in terms of their diagnoses and categories. Not only are medical diagnoses categories, but they are also devalued and stigmatizing categories.
			* Categorical devaluation allows society to view these individuals as their category, indistinguishable from others in the same category; therefore, categorized people are not viewed as individuals.

Others respond to devalued persons in terms of their membership in the stigma laden category.

* Individual qualities and actions become secondary....Individuals of devalued categories are treated as being...substitutable for each other....Stigmatized persons, then are little valued as persons.
* Classificatory status tends to displace alternative criteria of person worth....Others may claim license— implicitly, if not explicitly—to treat the stigmatized individuals in exploitative and degrading ways.
* To the general public, the biomedical model is the most familiar and best understood conception of disability.
	+ Two factors contribute to this: the long history of the model and the (seemingly)objective and scientific classification and diagnosis systems that render the biomedical model intuitively understandable to most people.
	+ A disability scholar, Bickenbach (1993), has proposed a third explanation for the public’s facile acceptance of the biomedical model, positing that this model has roots in a religious belief system in which disability was often (and may still be) viewed as a moral defect or the product of sin (of the person with the disability or their parents), and in which biological wholeness is viewed as virtue and righteousness.
	+ Therefore, the biomedical model appeared to add scientific confirmation to these religious beliefs. This combination of religion and science can be deep-rooted and powerful. In the biomedical model of disability, the location of the problem is within the individual, although clinicians would argue that the biomedical model does not involve blame or culpability for which the individual with the disability could be held responsible. Smart (2001) summarized:

The natural result of holding someone responsible for the disability is to hold that same person totally responsible for the treatment and the care of the disability. The rationale is, whoever created the situation, should also deal with it. Therefore the individual and his or her family should manage the disability and not subject others (who are totally blameless) to requests for assistance, accommodations, resources, or rights. (p. 103)

* If the problem exists within the individual, then all attention and efforts are focused on fixing or rehabilitating the individual. Neither the physical environment nor the social environment is thought to be part of the solution or part of the problem. The responsibility for both the problem and the solution lie within the individual with the disability.
* In this model, disability is an individual, personal matter. Further, the assumption that the individual is totally responsible for the etiology of the disability is stigmatizing for the individual with a disability.
	+ Blaming the individual for their disability results in prejudice, discrimination, and reduced opportunities for the individual, because it is thought that the individual should have done something to have prevented the disability.
	+ Explanation of the cause (etiology) of the disability often results in blame. The general public seeks for a cause and ultimately blames the individual. This is an example of how a model of disability can act as a source of prejudice and discrimination.
	+ The biomedical model is “often perceived to be that of experts delivering services to passive recipients who are expected to be compliant and to whom little information and few treatment options are presented”.
	+ Because the high skill levels and the years of training required to enter medical professions, the biomedical model relies on the use of experts. The individual with the disability is not considered to be an active decision maker, simply because they (most often) do not have the education, expertise, or experience required of physicians.
	+ In addition, once people are labeled as being disabled, they are socialized to the role. Everyone, with or without a disability, is socialized to certain roles (and the rules of these roles) within society. This model teaches the general public to consider the disability to be the “master status,” or the defining characteristic, of the individual.
	+ However, most individuals with disabilities do not view their disability as their primary identifier. Adherents of the biomedical model have stigmatized people with disabilities as victims with special needs. The Disability Rights movement has termed this as a “socially imposed disability.”
	+ In spite of these modifications to the ICIDH, the responsibility for dealing with a disability, according to the medical model, is doubly incumbent on the individual who has the disability. The individual is responsible for two types of responses: the medical/physical management of the disability and the emotional/cognitive response:
* In traditional medical views, the long-term or permanent functional limitations produced by physical impairment are called disability. Recent medical textbooks go further and construe disability as a variable dependent upon characteristic of motivation and adaptability as well as upon the limiting residue of disease and injury. However, both sets of medical views consider personal dysfunctional a sufficient criterion for disability.

By focusing on the individual’s motivation and adaptability, looking for solutions in the physical or social environment is not necessary.

* The individual with a disability is expected to be resilient, courageous, and to demonstrate self-control and optimism. The Disability Rights movement refers to this expectation as the “Try Harder” syndrome, and it is easy to understand that, if the individual is held totally responsible for the management of the disability, the general public is not required to provide accommodations (such as elevators, curb cuts, and Braille text) nor should the general public be required to accord civil rights to Americans with disabilities.
* Stone (1984) also regarded as troublesome the WHO’s attempt to separate medical, biological, and individual phenomena from the individual’s role functioning. She presented compelling arguments about the inaccuracy of medical diagnoses and, further, considered the clinician’s judgment of role functioning to be even more impressionistic, subjective, and value laden:

A third element of the impairment concept, the idea that the purely medical judgment of the impairment is separable from the more subjective and value-laden judgment of disability, is crystallized in a set of guidelines created by the American Medical Association to assist physicians in their certifying roles. (p. 110)

**Implications of the Biomedical Model**

* Most public and private disability programs rely on the biomedical model to some extent. Certainly, those who design and administer these programs rely on medical expertise.
* Eligibility to receive services is based upon the documentation of the presence of pathology and role limitation. Physicians are regarded as the gatekeepers to disability services, because they both define and subsequently establish the presence of a disability in an individual.
* The Disability Rights movement has termed this the “medicalization of disability.” Legislation in the United States, up until the passage of the ADA, tended to be incremental, simply adding layers of law, regulations, and policy to an underlying foundation based on the medical model. In turn, both the medical professions and government agencies have effectively educated the public (including people with disabilities) to believe that a condition is actually disabling.
* The biomedical model of disability has its origins in the historical two outcome paradigm of medicine. In the past, there were two outcomes to medical treatment: total recovery or death. Long-term chronic care is relatively new to the profession of medicine, because medicine’s history has been one of providing short-term care for acute needs. Presently, the management of disabilities consists of treating chronic conditions, avoiding secondary disabilities, maintaining a high quality of life, and treating symptoms. Naturally, the practice of medicine has evolved and expanded to include long term, chronic care, but some vestiges of the two-outcome paradigm are still apparent in insurance policies and disability programs that withdraw treatment and benefits once progress toward full recovery stops. This makes sense, because both the business of insurance and public and private disability programs was originally developed with the biomedical model of disability as a guiding assumption.
* The biomedical model of disability is better suited for physical disabilities than it is for cognitive, intellectual, emotional, and psychiatric disabilities. This is understandable, because, for centuries, physical disabilities were the only conditions regarded as disabilities. Yet, the definition of disability continues to expand and evolve; thus, impairments such as learning disabilities, mental illness, and addiction disorders do not lend themselves well to the biomedicalmodel, either for definitional assumptions, for causal andresponsibility attribution, or for treatment and policy considerations. Harlan Hahn (1988, 1993) was a gifted writer and disability activist who criticized the biomedical model of disability, citing its silence on issues of social justice (because disability is thought to be a private, individual matter), its legitimatization of the handicapism of the general population, and its fragmentation of the disability community.
* We have observed how the prestige and authority of science and medicine allowed the general public to detach itself from the issue of disability. Perhaps the greatest criticism of this model, according to Hahn (1988), was the resulting division of the disability community. The biomedical model separates individuals into diagnostic categories (the blind, the mentally ill, or the HIV-positive).
* Professionals and clinicians provide services based on the divisions of these categories, and the general public also subscribes to the categorical identity of people with disabilities. This categorization objectified and dehumanized people with disabilities; often, a person with disability was not thought of as “one of us.”Even more important, individuals with disabilities often thought of themselves as these categories. Rather than focusing on the universal problems of people with all types of disabilities, the disability community is divided along diagnostic, clinical categories, competing for both resources and civil rights. Bickenbach(1993)summarized:

Hahn believes that it has fragmented the disability community by stressing the functional traits that divided them rather than the external obstacles they faced as a common problem. Groups representing the rights of the people with disabilities are invariably organized around diagnostic categories and must compete among themselves for social attention. As a result, few broad attempts are made to form alliances or coalitions that might facilitate the emergence of a broad, social and political movement of citizens with various types of disabilities.

* The subordinate, inferior status of people is reinforced by the power differential present in the biomedical model. Because this model relies on the expertise and education of physicians and their diagnostic systems, people with disabilities have been socialized to assume a compliant, passive role. Therefore, the medical model of disability contributed to the fragmentation of the disability community in a second way:
	+ It taught individuals with disabilities to be dependent and inferior and certainly not to politically mobilize, demanding rights and accommodations. Hahn (1988, 1993) concluded his criticism of the biomedical model by terming it a “metahandicap,” meaning that the model contributes to prejudice and discrimination, and further, that the model itself is a handicap.
	+ Hahn was critical of the model’s emphasis on the relationship between causal factors of disability and outcome factors, advocating that these two phenomena are not related and serve only to increase prejudice and discrimination.
	+ By focusing attention away from the social and physical environments, the medical model is silent on issues of social justice. Further, powerful professions and policymaking bodies have endowed the medical model with the appearance of science, objectivity, and reality, thus legitimizing the handicapism of the general population.
	+ The biomedical model is one way to choose to view the disability experience. No disability scholar advocates the total abandonment of the medical model. Every disability scholar, however, advocates the total abandonment of the medical model. Indeed, the medical profession itself is moving away from many of the basic assumptions of the medical model.

**THE ECONOMIC MODEL OF DISABILITY OR IN A PERFECT WORLD, EVERYONE CONTRIBUTES ECONOMICALLY**

* Both the biomedical and the economic models of disability have their roots in well-established academic disciplines—biomedicine and economics— resulting in unchallenged positions in the general population, because these conceptions of disability are easily understandable and straightforward.
	+ Essentially, the economic model of disability defines disability as the inability to perform socially valued roles; most often work roles (sometimes referred to as “role failure”).
	+ Similar to the medical model of disability, the economic model of disability is normative, meaning that the desired condition is the ability to work and that deviance is, therefore, the inability to work. In short, although the biomedical model reduces the definition to the single dimension of biology, the economic model reduces the definition to an economic dimension.
	+ Those who subscribe to the economic model will accord respect, accommodations, and civil rights to people with disabilities, based on their perception of individuals’ potential to work and to provide economic resources.
	+ In the economic model, social assimilation for anyone is based on their (perceived) cost-effectiveness. Much like the biomedical model, the economic model has origins in value and religious systems. In many religions, the values of personal, moral, and social worth are closely related to the ability and willingness to work, and, further, a great deal of American legislation is based upon these principles.
	+ Certainly, the principles of self-reliance and individualism are enshrined in American culture. Also, throughout history, measuring (albeit subconsciously) an individual’s worth by their earning or production capacity has been commonplace.
	+ Accordingly, this model has the capability to shape the self-identity of people with disabilities, because those who do work and do not require public assistance typically are valued by society. Those individuals who consume scarce public resources, especially without (perceived) repayment, will be devalued. Many individuals with severe and multiple disabilities not only do not work and produce resources, but they also consume resources.
	+ An individual with a disability (who does not work) will be in a permanent position of dependence and indebtedness. These individuals are often labeled as “burdens” or “drains.”
	+ The public confers “civil inferiority” on people with disabilities who do not work. Higgins (1992) made a stronger statement: “Utility . . . cheapens people with disabilities....Utility merely ‘uses’ disabled people [sic]. If they and (the policy addressed toward them) cannot produce a ‘profit’ (i.e., if benefits do not exceed costs), then they have little or no value” (p. 199).
	+ As stated, the conception of normality is the ability to work and produce, and, accordingly, the definitions of the biomedical model and the economic model can conflict.
	+ Thus, in this model, not every impairment or disorder (as defined by the medical model) is a disability. For example, the professor in a wheelchair does not have a disability nor does the accountant with diabetes (in the economic model). However, the airline pilot with diabetes, a relatively easily controlled disability that does not carry much societal stigma, does have a disability. Therefore, in the economic model, disability is defined in relation to work requirements.
	+ Obviously, a disability for one type of work may not be a disability for another type of work. In the biomedical model, a disability is thought to be an individual trait (or problem) that goes with the person with disability to every setting. Therefore, judging the presence of a disability in the economic model is more difficult and complicated than it is in the biomedical model.
	+ In theory, the economic model is considered to be an interactive model that defines the disability in relation to aspects of the environment.
	+ The economic model of disability has been criticized on several fronts: First, there are disability activists, especially in the Independent Living movement, who question the definition of work as the only function considered. Activities such as leisure and community services are not discussed. Some have labeled the economic model as “the functional model,” but the term economic model is more accurate, because work and earning capacity are the only functions considered.
	+ Indeed, in large government censuses, work activity is routinely surveyed: In these large censuses, individuals with disabilities who are younger than 16 years and older than 64 years are not asked about their work activity, because they are assumed to be excused from work demands.
	+ The criticism of the economic model can be more readily understood from the following description:

The intellectual foundations of the concept of impairment are to be found in these industrial accident schedules. There are lists of physical or medical conditions, with a percentage of loss attached to each condition. Thus, the early schedules share two assumptions essential to the impairment concept.

First, they postulate a correspondence between a concrete bodily condition and a more abstract loss.

* + Some purport to describe loss of “earning capacity,” actual “economic loss,” or “loss of function.” But they all presume a link between bodily condition and some more abstract notion of performance.
	+ Second, the schedules all assume that a person (or more properly, a person’s ability to function) is a collection of arithmetically manipulable separate entities. Human performance is divided into percentiles, so that disability is conceived in terms of missing parts. Impairments become entities to be subtracted from the presumed wholeness of theindividual.
* Another criticism of the economic model concerns its failure to keep pace with the actual demands of the labor market. As the nature of work changes, the definition of work disability changes. Smart (2001) summarized:

The shift of the economy of the United States from an economy that depended on physical labor such as farming, mining, and manufacturing to an economy based on service and information processing has influenced the definition of disability. -=

-- In an economy based on physical labor, many individuals with cognitive disabilities, such as learning disabilities or mild mental retardation, were successful workers. In contrast, in that economy, an individual (especially a man) with a physical disability would have been severely limited.

* In today’s economy, a cognitive disability is much more limiting than a physical disability because service jobs and technology/information-processing jobs require high levels of cognitive functioning.
* Today, an individual with a physical disability, who has the use of assistive technology, has many employment options.
* Today, in contrast, most assistive technology designed for individuals with disabilities is computerized, highly technological, and capable of being customized to the individual. Such technology changes the definition of work demands (or the individual’s capabilities to meet the work demands)
* Changing socio-demographic characteristics and their effect on the labor market can render the laws that define work ability to be inflexible and obsolete.
* The labor market (the environment) changed. World War II was a time of great employment opportunities for many groups of disenfranchised peoples, including people with disabilities.

THE SOCIOPOLITICAL MODEL OF DISABILITY OR A PERFECT WORLD IS A WORLD IN WHICH PEOPLE WITH DISABILITIES ARE ACCORDED FULL CIVIL RIGHTS AND ACCOMMODATIONS

The sociopolitical model of disability requires a radical shift in perspective, specifically a shift in the location of the problem of disability, which, as we have seen, determines the response or solution.

* If the solution shifts, then the policy will also reflect this change. Radical shifts are neither easy nor fast. In the sociopolitical model, the environment is thought to be the problem, and therefore laws and policies will focus on rehabilitating the environment. The history of the model is short: Many scholars trace its genesis to the Independent Living movement and Disability Rights movement, which began in the 1960s.
* In the sociopolitical model, disability is defined as a social and civil construction, meaning that there is nothing inherent in a disability or individuals with disabilities that warrants prejudices, stereotypes, and reduced opportunities.
* Often, proponents of this model distinguish disability and impairment (the biological condition of the individual) from handicap (the social, attitudinal, and institutional barriers that people with disabilities experience).
* In other words, social structures can exaggerate disability and even construct disability. The behavior and attitudes of others (reduced opportunity and legalized prejudice and discrimination) have nothing to do with a disability. These disadvantages are socially constructed, and therefore they can also be changed or ameliorated without making any changes in the individual with the disability.
* If disability is socially constructed, it can also be reconstructed or deconstructed. Tamara Dembo, 20 years ago, asserted that disability is in the eye of the beholder: “Handicapping conditions are between people rather than in people....Curiously enough, if the handicap is not in a person, then there are no handicapped persons....Handicapped people exist only in the eyes of a viewer”.
* Itzak Perlman, the world-famous violinist and a survivor of polio, stated that people with disabilities experience two problems:
	+ 1) a physical environment that is not accessible, and
	+ 2) the attitudes of people without disabilities toward people with disabilities.
* Law disables people (and not a biological impairment within the individual). Further, the prestige and authority of law and government teach society to think of some people as having disabilities and to think of other people as not having disabilities.
* In addition, laws have the power to legalize, institutionalize, and legitimatize prejudice and discrimination toward people with disabilities.
* disabilities are also learned social roles, rather than behaviors and attitudes that are a direct result of a disability.
	+ In other words, society teaches people with disabilities to believe the meaning of the labels that society (and legislatures) attach to them and also to summit to prejudice, discrimination, and reduced opportunity, with equanimity—to be a good sport. Liachowitz termed this a self-inflicted disability.
* Laws and policies can have the power (and purpose) of medical classification systems (such as the ICIDI, the ICF, and the DSM–IV–R) because these formalized, collective public actions have become label makers and category makers.
* Individuals are housed, treated, and educated according to the provisions of these laws.
* As successive groups of people become objects of government legislation, disabilities experienced by these people become their category, their label, and, to some extent, their self-identity. Therefore, in the sociopolitical model, disability is a politically manipulated category. These manipulated categories affect the daily lives of individuals with disabilities, relieve society of the necessity to value and respect individuals with disabilities, and influence their self-identity.
* The sociopolitical model is an interactional model, because it considers both the individual with a disability and their situation. Policy makers, professional service providers, and the general public are part of the problem of disability, or, stated differently, if disability is a collective concern, then the response required is a collective duty. If society does not respond, it can be said to choose to refuse to pay the price to remove barriers and discrimination.
* In contrast to biomedical and economic models, the sociopolitical model has no academic/professional field of expertise to provide a theoretical foundation. As we have seen, the appeal to a single field of expertise has four results:
	+ First, the professional field defines and describes disability and its treatment;
	+ second, a power differential is put into place;
	+ third, and perhaps most important, people with disabilities are segmented and stratified by varying classification systems, service providers, and bureaucratic organizations; and
	+ fourth, it excuses society from the need to respond, simply because the public thinks that professionals can and do meet all needs of people with disabilities.
* Stated differently, models that have professional fields of expertise diffuse responsibility for disability among the differing types of service providers. Individuals who experience disability are beginning to communicate their conception of disability, often indirect contrast to that of professional caregivers.
	+ The most clear-cut example of this is the Deaf culture, who define themselves as having a separate culture, rather than as a disability group. Citing the use of sign language (a rich repository of culture, tradition, and mutual understanding) and their group cohesiveness, the Deaf culture refuses to accept the normative role of “the disabled.” In doing so, they have freed themselves from what they view as professional tyranny.
	+ Many consider the sociopolitical model to be the most powerful model of disability, because this model, of the three discussed here, is the only model that has mobilized people with disabilities. In contrast, the biomedical and economic models have divided and isolated Americans with disabilities, by their insistence on viewing disability as individual and biological phenomena. If the value of models of disability is twofold (to explain as accurately and precisely as possible and to develop guidelines to human action), then the sociopolitical model of disability has the greatest accuracy and power.

COMPETING DISCOURSES AND COMPETING FOR RESOURCES

We began our discussion of these models of disability by emphasizing that none is reality itself. Nonetheless, we have seen that the general public had often thought of these models as total reality.

* No one model completely describes the disability experience, in large part, because of the one-dimensional definition of disability that each model provides.
* Disability is a complex, multivariate experience that exists in a social environment, and therefore these incomplete definitions distort the representation of the experience.
* If the models are incomplete in defining disability, then it follows that each focuses on a single set of problems, which does not and cannot give an accurate and complete picture of the lived experience of a disability. For example, if an individual cannot find and obtain employment, the economic model would best describe their disability experience. But no individual with a disability neatly divides up their life into three models.
* Among the three models discussed here, the sociopolitical model most accurately and completely describes the daily lived lives of people with disabilities, because most of the difficulties they experience are more social in nature than has previously been acknowledged.
* However, the sociopolitical model represents a challenge to traditional patterns of thought and action.
* Here is the problem. Disability laws and policies trace their origins to a theoretical foundation in a single model of disability. Indeed, many experts view the development of disability law and policy as neither comprehensive nor unified.
* In their view, all models are capable of change, and, indeed, if they are to continue in use, they are required to change.
	+ The biomedical model of disability had added the concepts of disability and handicap to the definition of impairment, and
	+ the economic model had made, and will continue to make, adaptations, based on changes in the labor market and advances in assistive technology. However, perhaps because of their long history, their appeal to (seemingly) intuitive public understanding, and their roots in religion, medicine, and economics, it seems doubtful if these changes in these two models have been acknowledged or understood by the general public. For instance, Nagi (1980) published his differential classification of impairment, disability, and handicap, in an attempt to render the medical model interactional (attempting to take the broader environment into consideration). This was almost 25 years ago, and yet, today, most people, including professional service providers, consider the three terms to be synonymous and interchangeable. The newer ICF has attempted to heighten clinicians’ sensitivity to environment and functioning; thus, it appears that the medical profession itself is moving beyond the medical model of disability. The sociopolitical model, in contrast, has as it primary tenet that disability is created by society, and therefore, if society makes disability, society can also remake disability. Is this a contest among models? Or, can the history of these models of disability be thought of as in an ascendant trajectory, with the sociopolitical model being the strongest and most accurate? On the one hand, no one advocates the complete abandonment of the medical model (including people with disabilities) ; on the other hand, no one(including people with disabilities) considers the sociopolitical model to be a complete definition of, and total solution to, the experience of disability. However, most disability scholars question the capability of the biomedical model to incorporate the political demands of people with disabilities.
	+ These three models can be thought of as building upon each other: Certainly, the biomedical model is viewed as a starting point from which to understand disability. However, they can also, in this time of limited resources and rationed services, be thought of as competing discourses, because each model guides policy formulation and implements service provision in very different ways.
	+ Obviously, there are not resources available to respond to each of these models.
	+ Each model, in addition, provides definitions and underlying assumptions of disability that shape public perception. Some of these definitions are in direct conflict with each other. How is the public to decide on the most accurate definition? How are individuals with disabilities to shape their self-identities?
	+ This discussion on the three models of disability raises more questions than it answers. Is this a contest among models or an ascendant trajectory? The answer is “yes” to both. Disability is a combination of biology and social construction. Nonetheless, at minimum, we now possess some basis to pose these questions.

Rehabilitation and Disability

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|  | Rehabilitation is a complex process that involves a number of healthcare professionals, the individual and their family. Rehabilitation is becoming more of apriority in some countries, which prioritize rehabilitation in health care. The aim of this section is to discuss rehabilitation at a macro and micro level by: • Discussing the history of rehabilitation• Identifying the major government agendas related to rehabilitation • Discussing what rehabilitation is both in terms of a process and a philosophy • Exploring the related concepts of teamwork and quality of life.In order to achieve this there are a number of theories and models which can be used to make sense of rehabilitation and which can assist rehabilitation professionals. |

History of rehabilitation

Rehabilitation is seen widely by many as being an essential part of a patient's care, as it is here that a person has the opportunity to fulfill his or her potential. Rehabilitation has attracted little attention and has been rarely mentioned within health and social policy, and, as a result, rehabilitation services have received poor funding. Because of the under-resourcing of rehabilitation, few areas have adequate services, which meant that individuals are unable to receive the support required. Such underfunding and general lack of focus received by rehabilitation within health and social policy can be attributed to several issues.

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| REHABILITATION  | There are many definitions of rehabilitation within the literature but they all highlight similar defining attributes of rehabilitation: |
| Process Restoration | Rehabilitation is generally described as being an active, dynamic, continuing process concerned with physical, social and psychological aspects. Rehabilitation is characterized as a continuous process and identifies the 'rehab cycle', which aims to improve an individual's health status and quality of life by minimizing the consequences of disease. The **cycle consists of five stages**: • Identifying problems and needs • Relating the problems to factors that are limiting and can be modified • Defining target problems and target mediators and selecting appropriate measures• Planning, implementing and coordinating interventions • Assessing effects. The last stage of the cycle may cause new problems and needs to be identified, in which case the cycle begins again.In relation to rehabilitation, 'restoration' involves enabling the individual to regain lost elements of their life, such as physical functioning or personal and social identity. It also carries the sense of restoring the individual to society or to a purposeful and satisfying life. The use of the word 'restore' can imply that the emphasis of rehabilitation is on the individual returning to their former life. However, the definitions tend to interpret 'restore' in terms of individuals adapting to changed circumstances and learning new skills rather than returning to their former life roles. Pryor (2002) identifies rehabilitation as being the reconstruction of individuals' lives in the light of injury, illness or surgery. She sees rehabilitation as being about lives that are lived in damaged or broken bodies. |
| Effectiveness Enabling and facilitating  | Rehabilitation is described as promoting effectiveness or optimal functioning for the individual. Optimal functioning is implied as being functioning that can be achieved given any limitations the individual may have. Functioning could be interpreted in terms of emotional and psychological functioning as well as physical functioning.Rehabilitation is generally described as being an enabling and facilitating process rather than a 'passive, doing for' process. This is conducive to rehabilitation being active rather than passive. In order for healthcare professionals to take on this enabling and facilitating role the relationship between them and the individual may need to be different. An interesting question is: where does the power lie in this kind of relationship? |
| Learning and teaching | Learning and teaching is implied within some definitions, in terms of rehabilitation being described as an educational process that enables patients and carers to learn new skills. Wade (1990) describes it as an educational, problem-solving process aimed at reducing disability and handicap. Applying the International Classification of Functioning, Disability and Health (ICF; World Health Organization 2001), this could be interpreted as increasing an individual’s activity and participation. |
| Autonomy | Autonomy is implied in some of the definitions, in terms of enabling individuals to achieve goals that are important to them. In another different definition, the stress is that rehabilitation should be a process aimed at restoring personal autonomy in those aspects of daily living considered most relevant by individuals and their family carers. This idea of restoring personal autonomy fits in well with goal planning and the concepts of empowerment and advocacy. Taking autonomy one step further, Cardolet al (2002) suggest that autonomy should be the ultimate aim of rehabilitation. In order for this to happen, health-care professionals will need to explore the concepts associated with autonomy- e.g. power, empowerment- and their implications. |
| The International Classification of Functioning. Disability and Health | Rehabilitation can be considered in terms of the ICF (World Health Organization2001) under the classifications of impairment, activity and participation. Rehabilitation goals will be different related to each level. Using the ICF as a framework for rehabilitation ensures that the focus of rehabilitation is not only on the level of impairment and disability. It needs to focus on the individual's participation in the environment and in society. The goals at each level of the ICF will generally relate to each other. For example for an individual who has had a stroke the goals at each level might be as listed in Table1.1.*Relationship of ICF categories to goals*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ICF Category Goal Impairment To regain function in hemiplegic arm and to prevent  complicationActivity To be independent in washing and dressing Participation To be able to return to work The goals identified at the level of participation may be dependent on the achievement of goals at the levels of impairment and activity. The ICF in relation to rehabilitation is discussed later |
| Philosophy | As well as a process, rehabilitation can also be considered as being a philosophy of care. It is about the way professionals think about individuals and where they see their role in the process. As a philosophy, rehabilitation is about enabling, facilitating, empowering. Adopting this philosophy of rehabilitation means that health-care professionals: • Value the patient as an individual, identifying their strengths and weaknesses; their past achievements; their hopes for their future. This is vital if professionals are to deliver client-centered care. Using assessment tools that assess individual's strengths, weaknesses, etc. can help to promote this value. • Adopt strategies that facilitate and enable the individual to achieve their full potential. It is important that there is some continuity in the strategies used by rehabilitation professionals and that there is agreement as to what constitutes facilitating and enabling strategies. • Realize that, although it may be necessary to devote more time to enabling individuals to achieve their full potential, this will be cost effective in the long term. It can be difficult to take this view, particularly in an environment where rehabilitation is not seen as a priority. The time involved is perhaps the most common factor identified by health-care professionals in acute settings as a barrier to rehabilitation. However, health-care professionals need to consider whether this is a valid argument when set against the consequences of not promoting rehabilitation, both for the individual and for health-care resources. Not promoting rehabilitation in the acute setting may mean, for example, that the individual will not achieve their full potential given their limitations and will therefore need more resources and support after being discharged. • Should be thinking about how the individual and their family will manage in the future, even though the extent to which they are able to affect the individual's level of participation may be limited. The focus should be on individuals' future quality of life as they see it. |
| Stages of Rehabilitation  | One of the remaining difficulties is that rehabilitation can be seen as something that happens in a specialized unit or ward whereas in reality it needs to commence the moment an individual enters the health-care system. This may be at the first contact with the GP or as an emergency case in Accident &Emergency. It can be helpful to consider this continuum of rehabilitation as having four stages. The aims of rehabilitation are different at each stage.Stage 1This is the initial critical stage when the individual is unconscious. The goal of rehabilitation at this stage is to preserve life. Interventions at this stage include: • Preventing complications • Providing verbal and tactile stimulation • Supporting relatives.Stage 2At this stage the individual has recovered consciousness, is fully responsive and is beginning to regain some physical function. The goal of rehabilitation depends on the individual's needs. It may be to maintain a safe, comfortable environment, which may be an appropriate goal for an individual with a head injury who is agitated, or it may relate to the individual's functional and cognitive ability. Interventions may include: • Managing challenging behavior• Assessing the individual's functional and cognitive ability • Establishing everyday activities, e.g. eating at a table, using the toilet rather than a commode• Giving the individual choices, e.g. about diet, clothes • Establishing alternative forms of communication • Supporting and involving relatives.Stage 3A more active program of rehabilitation is required at this stage, which may take place in a rehabilitation ward or center. The goals of rehabilitation should be focused on the level of participation- being concerned with the individual's quality of life. This will involve: • Facilitating and enabling individuals to achieve their maximum potential in washing, dressing, feeding, communication and mobility • Ensuring that there is continuity of therapy programs between the different professional groups within the team • Empowering individuals by giving them informed choice and by involving them in the setting of rehabilitation goals • Providing psychological support to the individual and their family • Providing a supportive, structured environment for the individual and family.Stage 4The individual will have reached their full potential at this stage. The focus will now be on enabling them to live with the disabilities they have and maintaining their quality of life in relation to work, hobbies and social life. At this stage they will either be at home or in an alternative setting, e.g. a nursing home. They may attend a young disabled unit for respite care or other day facilities, where the role of the team is to help them maintain their quality of life. In order for individuals to maintain their full potential, they may need follow-up appointments with the rehabilitation team, which may result in further assessments and interventions. |
| Rehabilitation and Disability  | Looking at rehabilitation in terms of four stages highlights the need for rehabilitation to be a team activity. The goals of rehabilitation at each stage will depend on the individual's impairments and the resulting disability or the limitations that the impairment places on their activities. Because of the effect the individual's disabilities can have on the rehabilitation process and outcomes it is useful to consider the relationship between rehabilitation and disability. . According to one survey on the meaning of rehabilitation and disability, professional and client groups view disability as being a dramatic life change for the individual, with rehabilitation being an enabling process in which a range of groups in society worked to meet the needs of the disabled person. This life change includes the way in which individuals see themselves and others. The report emphasized that disability should be related to the individual person with a disability rather than 'the disabled'. The use of disability languages is an important consideration. The term 'the disabled' is still used in the media and in literature, as well as in many countries. Disability languages are* Person-first language( person with a disability
* Disability –first language (disabled person)

This kind of language can be seen as discriminatory, as it implies that disabled people are not seen as individuals but are defined by their disability. There are views in the literature on the relevance of rehabilitation to people who are disabled. Some of these views highlight the framework of the ICF (WorldHealthOrganization2001) that includes the idea of level of participation, which identifies environment and societal factors. This enables disabilities to be described from the perspective of an individual's life circumstances and the impact these have on their experience. The focus on environmental and social factors fits in with Pryor's (2002) description of the creation of a 'rehabilitative milieu', by which she means an environment that enhances the process and outcome of rehabilitation. To enable this environment to be created, thought has to be given to the participants, the activities and the setting in which they take place (Pryor 2002). It is interesting to consider whether definitions of rehabilitation reflect the cultures of different countries. For example, in some countries rehabilitation may be seen as synonymous with physiotherapy. The goal of promoting autonomy and independence may not be congruent with the beliefs of individuals from different cultures. For example, a study comparing Asian people's attitudes to family values with those of white people in the UK found that Asian people valued conformity and self-direction less than the people in the UK. This may not be congruent with the concepts of autonomy and independence. It is therefore essential that rehabilitation is focused on the individual's needs and goals and that their values and beliefs are taken into account. It cannot be assumed that all individuals or professionals have the same views about rehabilitation. In order for professionals to deliver culturally competent rehabilitation care they need to:• Be aware of their own attitudes towards diversity and examine these attitudes • Be sensitive to and respect differences • Be knowledgeable about different cultures to enable them to interpret behaviors appropriately • Have cultural skills that enable them to respect and value culture - this may include the use of appropriate touch and non-touch when communicating and respecting the individual's need for physical space • Be able to communicate cross-culturally, which may mean the involvement of interpreters or people in the community.Focusing on what is important to the individual and what their goals are transcends all cultures. |

TEAMWORK

Rehabilitation, because of its complex nature, cannot be achieved by one professional group alone. Rehabilitation has become synonymous with teamwork. A review of the literature on trends in rehabilitation policy highlighted the need for rehabilitation to be centered on the most important aspects of an individual's life with the involvement of service users. To enable this to be achieved rehabilitation needs to involve a group of professionals all working with the same purpose of meeting the individual's goals. This process must involve the individual and their family. One definition of rehabilitation: 'a process aiming to restore personal autonomy in those aspects of daily living considered most relevant by patients or service users, and their family carers' also highlights the need for a multiprofessional approach to rehabilitation.

* This definition also focuses on individual-centered care, emphasizing what service users and their carers, not the professionals, see as important. The five main principles of individual-centered care can be identified as being
	+ empowerment of individuals,
	+ enhancement of staff,
	+ multidisciplinary integrated pathways,
	+ multidisciplinary teamwork and
	+ restructuring and decentralization of services.

One could argue that truly individual-centered care requires interdisciplinary teamwork in which there is not only a shared philosophy and collaboration but also blurring of professional roles in order to meet the individual's goals.

* This use of terminology brings into question the different terms used when talking about rehabilitation. Terms such as multiprofessional, interprofessional, transprofessional, multidisciplinary, interdisciplinary and transdisciplinary are often used interchangeably. What is the difference between professional and disciplinary? Between multi- and inter-?

Table1.2 gives some dictionary definitions. 'Multi-' implies that there are a number of different professional groups working together, whereas 'inter-'implies that there are a number of different professionals working together towards a common purpose and that there is some blurring of boundaries. 'Professional' can be taken to mean the different professional groups whereas 'disciplinary' can be taken to refer to the knowledge and skills underlying different professional roles.

Table 1.2 Definitions of team types

Term ProfessionaI

Disciplinary

MultiInter

Definitions of Team Types (Oxford Paperback Dictionary1998) Someone who belongs to aprofession, which isanoccupation that involves knowledge and trainig at an advanced level of learning Oforfor adiscipline, which isdescribed astraining that produces aparticular skill;orabranch of learning orinstruction Involving many Between oramong

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This is supported by Payne (2000), who distinguishes between'professional'and'disciplinary'by suggestingthat'professional' is concerned with the functions and activities associated with the different professional groups, whereas 'disciplinary' is concerned with the knowledge and skills required for different professional roles. Norrefalk (2003) takes on the challengeof trying to make sense of the different terminology and identifies that: • Amultidisciplinary team • Involves the efforts of individualsfrom a numberof disciplines • Isusedto describe a team consistingof manydifferentprofessions workingin rehabilitation • In an interdisciplinary team • Members notonly require the skills of their own disciplinesbut also have the added responsibility of the group effort on behalfof the activity or individualinvolved • The skills necessary for group interactionare required, and the knowledgeof howto transfer integrated group activities into a result thatis greater than the simplesumof the activities of each individual discipline • The group activity is synergistic • In a transdisciplinary team • Allborders arebroken betweenthe individualprofessionals.One member ofthe team actsasa primarytherapist, being supportedby therestofthe team.Thisprimarytherapistmay bea health-eare assistantwith specificrehabilitationtraining (jackson& Davies1995). The terms 'discipline'and'professional'can beidentified ashavingmore or less the same meaning. Norrefalk (2003) makes the point that it is importantthat rehabilitationprofessionals nationally and internationally use the same terminologywiththe same meaning. He makes the suggestion that 'multiprofessional team' is used rather than 'multidisciplinary team'. As the team consists of different professionals, this does perhaps make sense. However, there can still be seen to be a difference between 'multi-'and 'inter-', with the interprofessional team truly workingacross boundariesinordertomeetthe goals thatare importantto the individual and havebeen identified by them. This fits in with the view of McGrath & Davis (1992), who consider the distinction between multidisciplinary and interdisciplinary to be their focus, with 'multidisciplinary' being focused on the levelofactivity and'interdisciplinary'focused on the level of participation. It is the level of participation that enables goals to be more realisticfor the individual.In rehabilitation,professionalsshouldbe working towards goals thatare importantto the individual.

Collaboration Collaboration is the key to effective team workingand can be described as the process of working towardsacommongoal with sharedplanning

Figure 1.1 Concepts related to collaboration

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andaction. The team has joint responsibilityfor the outcome(Lindeke & Block1998). Interdisciplinary collaborative care differs from multidisciplinary collaborative care in that it involves joint decision making, shared responsibility andshared authority (Lindeke & Block1998).Professionals work together and cooperatively to achieve an agreed individual-centred goal. Transdisciplinary care takes this way of working onestep furtherinthat thereisacompleteblurringofgoals withone person being responsible for ensuring that the individual's needs are met (Hutchings et al 2003). Although collaboration is the ultimate aim in practice it isnot always easy to achieve. Freemanet al (2000), as a result oflooking atcasestudiesofsixteams, identifiedthatdifficulties in developingcollaborative practicecan be identified at the levels of the organisation, the groupandthe individual.There are anumberofconceptsthat affectall these levels, whichneed to be taken into account for collaboration to occur. Figure 1.1 identifies concepts related to collaboration, which are the basis fora taughtmoduleon collaborationat the Schoolof Health andSocialCare, Oxford BrookesUniversity. Althoughteam workingisseen asbeingcentral to rehabilitation there islittle publishedevidencefor its effectiveness (Embling 1995,Waters & Luker 1996,Proctor-ChildsetaI1998).There isevidenceat aclinicallevel fromprofessionalswhohavechangedfrom one approachtoanotherthat it does have an effect on individuals (McGrath & Davis 1992). Using acasestudyapproach,Proctor-Childset al(1998) explored the realities of multi- and interdisciplinary teamwork. Although this was a small study using only two case studies,both from a neurorehabilitation setting, the findings support the work of McGrath & Davis (1992). Proctor-Childs