2.3. The Social and Medical Model of Disability-Affirmative, Environmental, Attitudinal

This is the two pragmatic models of disability, though there is the psychological and the most recent one, the administrative or charity model. Some expert has argued that disability is a personal tragedy or part of life caused by societal barriers, while other overview it as a medicalization problem. What is essential is our ability to comprehend what it really means to people and how effectively we are able to address it without misconstruing it with the term of impairment.

For the purpose of this research work, I shall give a broader base to the social model of disability which is in tandem to my research focus. However, I shall consider the tentative affirmative model of disability which is an intermediary between the medical and social model as suggested by Cameron (Cameron, 2008:19).
2.3.1. Medical or individual model of disability

The medical model of disability see disability as a problem that solemnly belong to an individual with disability. It is not seen as an issue to concern some else with, rather than the individual. In this approach, it is believed that individuals with disability has a problem with his or her body thereby, limited in performing their daily role as a result of the body problem and not socio-cultural milieu. The general schema before, is the medical model of disability. The medical model has limited the person’s with disability to the notion, that their predicament can only be resolved through the medicalization mean. Over the years, as the issues of disability is becoming a general discourse, thus evolving disability people's rights, the medical model is being criticized fundamentally. Despite its challenges it has not yet be supplanted, it long existed before the advent of other models of disability.

The critique of the medical model of disability by Oliver (1990) in his article, The Individual and Social Models of Disability argued that since disability is relatively a long term social state, it is not treatable and is surely not curable. Oliver argues, that the whole medical and rehabilitation initiative is established upon the precept of normality. Aiming at restoring the disabled people to normality. The doctors (professionals), as society experts, they do have major significance in the society and a great deal of power thereby using their medical noesis and skills in an attempt to treat disability instead of illness.

In this medical approach, the doctors tries to confine the disabled people within their medical cognition, which mostly or overall is unsuitable as they are but yet it being forced on them. Oliver (1990) suggested, doctors need to have a rethink and should agree that with this approach there is much limitation or confinement to the medical theories which is alien to the literally meaning of disability. Oliver argued that if doctors will use their medical theories to solve disability issues, then doctor should have also been able to use their medical expertise to mould the kind of place the disabled people should live, work or interact.

Fortunately the disabled people, individually and collectively are coming to reject the prescription of ‘normality’, instead increasing demanding society accept them, the way they are and not how society thinks they should be.

The medical model of disability lives on the ideas that a disabled person have a disability, through this idea the person is prevented from functioning in the society with their body or brain. An inherent problem we need to adjudicate first, is to find out which facet of the disabled people's live need medical intervention and which facet needs policy development or political action (Oliver, 1996). Oliver assured that failure to find out or check this as lead to the medicalization of disability and the society experts see this as the suitable responses.

Morris (1991) has a diverging view to Oliver (1996) submission, in his article of Pride against Prejudice, Morris believes that though while some environmental obstacles and social attitudes are sensitive part of the experience of disability which disables them, he quickly suggested that there is also the personal experience of physical or the intellectual limitation, of illness, of fear of dying.

The medical model looks at disability as a functional impact of impairment without acknowledging the environmental dimension.it thus mean to put the blame for the problem entirely on disabled individual (Geiecker et al., 2001).it stays within the tradition of regarding disability as a deviation from the norm, completely ignoring all other individual and societal factors that all together constitute the phenomenon of disability. To this end, when we ask people what disability is, we will get different response and viewpoint. Some people will still say disability is a personal tragedy (Crow 1996; Morris 1991; WSilliams 1991).Some sees it as a medical problem because of the medical stigmatisation (McKnight 2005; Rieser & Mason 1992; Zola 2005) other say this is just part of life inherited from societal barriers (DPI 1982, Hevey 1992, Oliver 1996). The medical stigmatisation process is reflected to on the perspective of the medical model, under the evaluation of Harris and Enfield (2003), hanging the problem of disability to a ‘disabled individual’. Person’s with disability needs special services such as special transport system and welfare social service. Based on Harris and Enfield submission about the medical model, we have seen the emerging special institutions with medical profession, therapist, and special instructor determining how to provide special treatment, education and occupation for disabled people.

2.3.2. Social model of disability

In discussing or researching about the different models of disability, it vague the basic matters relating to disability. Fundamentally disability is all about being oppressed, being discriminated against, poverty and
inequality which are embedded in the social models of disability. Thus making the social approach acceptable through re-orienting the person’s with disability and yielding positive result in the lives of the disabled people. Oliver (1990), as one of the mastermind behind the lately discussions about the models of disability, reasoned that the social model of disability does not contradict the problem of disability but he turned it up forthrightly on the society. It is the society inability to provide accessible environment and adequately ensuring, that the system do not discriminate against disable people.

The evolving discernment about disability challenges the traditional point of view that disability is purely a medical problem. In the medical approach, it focus on means of ‘curing’ individuals with disability in order to fit them into society. It leaves the individual with the notion that the disabled person has to change, not the surrounding environment or society.

Drawing from Harris and Enfield (2013), the problem of disability is the ‘disabling society’. With the denial of basic human rights, limited access to adequate health service, education, employment opportunities, participation in decision making, exclusion from social activities and discriminatory laws. For example, to someone that has a mobility impairment and using the wheelchair, if she is unable to access a building or a public transport because there are no ramps or lift, in thus mean the society has discriminated by limiting or restricting his or her movement. This is the concerns of what the social model of disability tends toward, that we are not ‘people with disability’ but ‘disabled people’. Our society do not provide an equal enabling environment for us, they do not see us as being equal to the so called ‘normal people’. The society does this, through segregates us with their designs, policies and political action (Oliver, 1990).

Oliver (1990) view was being supported by Parker (1993), whose thought are that, he saw people being disabled by the physical, economic and social environment. Oliver (1990) and Parker (1993) views aligned with Harlan Hahn and late Irving Zola, the founding fathers of the social model description in the United State. More than three decades ago, Harlan Hahn and late Irving Zola (198 as cited in Drum, 2014), contends that disability is not an accident to be foreclosed or a specific impairment but, consequences of lacking being physical fit and healthy between underlying impairments and social, architectural, economical, medical and political environment.

When I read about people like Lisa Egan (2012), a disability right activist and an occasional writer who reside in the United Kingdom. She has been disabled at birth and had to live with the miff that the medical model of disability availed for her. I am deeply convinced and my mind is positive about the expansiveness of the social model. According to Lisa Egan, the social model has speedily changed the perspectives of person’s with disability. It aid them moved away from the medical stigmatization to the new hope that with their different forms of disabilities they can however function adequately and independently, if there is an enabling milieu. The case of Lisa Egan (2012) was astonishing when she became uncovered to social model. Her mind became different in some respect and she believed she was not a ‘person with disabilities’ but a ‘disabled person’. She was positive that she didn’t have ‘disability’ but was being ‘disabled’ more unconditionally by the society, that set out social, attitudinal and architectural barriers her ways and many others.

Figure 1 LISA EGAN (DISABILITY RIGHT ACTIVIST) ON HER WHEEL CHAIR

I was further struck in my mind about the social model of disability in Lisa Egan (2012) analogy of the ‘wireless network connection’. She states that when we turn the wireless connection off our computer, we are being told that the connection has been disabled. She then asked this question, does it mean that suddenly the Wi-Fi has become less-able? Or acquired disability? No, these completely prove that there is an external forces that determine the disability. This peculiar external forces or factor is our society and majorly the policies makers.

Often time the society discriminate by treating disabled people as second class citizen by ineffective and inaccessible environment. For example, Hannah Cockroft, a British wheel chair athlete that specialises in sport distance in the T34 classification. Hannah Cockroft is not someone that can be referred to as a person with disability because she is not capable of being stopped on the athletic tracks. She becomes disabled when she tries to access the public space because of the man-made impediments e.g. the stairs, escalator etc. without the option of the ramps, lift etc.

Figure 2 HANNNAH COCKROFT, A BRITISH WHEEL CHAIR ATHLETE IN T34 CLASSIFICATION

To me, Hannah Cockroft, being unstoppable on the athlete track and stoppable by those impediment on the other public space is an assertion of the social model of disability. It clearly vindicate the social model of
disability notions and the rest lies on us to remain adamant on our government to become more sensitive to our plight. (Lisa, 2012).

The disabled people's organisation are working graciously within the framework the social model of disability avail them with. They indeed supported it to medical model. DPI believed that the social model is for them, while the medical or individual model is what the policies makers or the political class want them to believe and live with. Their accomplishment has been to separate the nexus between their bodies and the social position thereby concentrating on real ground of disability. eg discrimination and prejudice (Shakespeare, 1992). The social model has recorded great impact on the disabled people. (Oliver 1990).

2.3.3. Affirmative model of disability

Some disability studies writers criticises the social model of disability. The disabled feminists have stated that the social model over emphasises socio-structural barrier, ignoring personal aspect of disability (Rousso 2013; Thompson 2005; Wendell 1996). There is some validity to this, because the social model of disability was invented by those with physical impairment and this partially manifest their experiences. (Shakespeare, 1996)

Owing to criticisms made by some social-modellists, the social model is been reduced to a tool that focus on social structural alone (Barnes, 2007). Though, the originator of the social model stated that the social model of disability is not an all-encompassing theory of disability (Oliver, 1996) but a framework through which disability can be seen as social process. The social model critics have based their arguments on Oliver’s submission. Thereby looking beyond the socio-cultural milieu to suggest that ‘there is a tendency within the social model of disability to deny the experiences of our bodies’ (Morris, 1991) and a need for a renewed social model which would allow ‘a more complete recognition and understanding of individual’s experience of their bodies’ (Crow, 1996).

Cameron (2008) in justify the affirmative model, explained that social model of disability reflects ‘positioning decision’ (structural and environmental barriers) rather than a ‘weakness’ and to this end affirmative model could be seen as an intermediary between an individual model and social model of disability.

Swain and French (2000, as cited in Cameron, 2008) proposed an affirmative model as seeing ‘disability and impairment with a non-tragic view. Basically to have positive social identities both individually and collectively, for disabled people grounded in the benefits of lifestyle of being impaired and disabled’. The affirmative model proposal argues for the need for an extension to the social model, in order to include the ‘personal’ Cameron (2008). With the hope to move away from the social model concept of disabled people celebrating their differences and get to a positioning of thinking differently about being different both individually and collectively.

To me I contend that the affirmative model is an idea, not a model. it can’t replace the social model. Most time an idea could turn-up to models as observed by Mike Oliver ‘models are ways of translating ideas into practise’ (Oliver, 2004). This ideas could be merged to the social model of disability, which will make the social model robust in dealing with the emerging disability challenges. Cameron re-affirm this contention by defining affirmative model of disability tentatively as the loss or limitation of opportunities to take part in community life on an equal level with others due to physical and social barriers (Cameron, 2008:24).

The difference in the affirmative model definition is the ‘community life’ as against social model usage of ‘normal life’ (DPI, 1982). The affirmative model views the ‘normal life’ as a problematic concept, which leaves disability as an unequal social relationship.

2.3.4. Environmental barriers

The social model has always required that both the physical built environmental and attitudes of society as a whole change to accommodate disability in all of it form. Public buildings like health clinics, schools, mall, offices, shops and public transports and market places are often not accessible to person with physical disabilities. This are physical barrier (environmental) preventing persons with disabilities from public participation.

The concept of social model of disability is to fix inaccessible factors in the environment that disables. Abberley (1987) and Oliver (1990, 1991), view disability issues as an inherent social phenomenon, which environmental barriers can’t be excluded. There are lots of situations in the environment that are disabling. Hence, distinction needs to make between those environmental barriers that can be changed. For example a mountain or a hill cannot be change but a stairs can be changed into ramps or replaced by elevators. (Bruijn, 2012).
Communication and information poses barrier to persons with hearing, speech or visual impairment, if the information is been presented in an inaccessible format. Nevertheless, the research focus of this work is on physical mobility, where environmental barrier play a major role.

2.3.5. Altitudinal barriers
Disability can have a psycho-emotional dimensions as a result of attitudinal issue posed from non-disabled people, which includes being stared at or patronised by strangers, actions which can leave disabled people feeling worthless and ashamed, and may end up preventing them from participating in society as effectively as physically inaccessible environments (Reeve, 2006). Looking at the underlying state of uncertainty experienced by many disabled people in relation to how they are being perceived and welcomed by others around them; something like the easily-awakened awareness of the likelihood that they are being watched or seen as deficient, of low intelligence, incompetent and unfortunate. To me attitudinal barriers poses more danger to the celebrated environmental barriers. Disabled people experiences ‘tension’ as a result of attitudes of non-disabled people (Cameron, 2010). The knowledge that other people avoid contact with them because they are disabled, as if somehow their disabilities was contagious or as if being seen with them would be a cause of embarrassment. Borrowing from Cal Montgomery: those little acts of degradation to which others subject us... those little reminders that we need to know our place in the world (Montgomery, 2006:unpaged).

As Montgomery comments:
Every few hours I run up against people who feel free to remind me that I’m their inferior and that I should conform to whatever they’ve decided ‘people like [me]’ are supposed to be like (Montgomery, 2006: unpaged).

Bruijn et al. (2012), submitted that people with disabilities have environmental barriers which seriously affects their participation and functioning in society. But, in reality, the attitudes society holds on disabled people marginalises them and thus reflects on disabled people’s lack of self-esteem and motivation to contribute towards their own development. Non-disabled people can respond with pity, fear and antipathy, or with sense of superiority. This form of ignominy and discrimination poses one of the biggest problems for disabled people. The use of vain languages—‘handicap’, ‘victim’, ‘leper’ or ‘crippled’ reverberate and reinforces prejudices, which make disabled people to look at themselves with an inferior identity (Bruijn et al., 2012).

Thinking about disability in this way is crucial, if we want a society that is fairer and more inclusive. If we are tempted to dismiss the threat of attitudinal issue, what do we have to say to the question asked by Geiecker, Otto, Momm and Willi (2001). Geiecker et al. asked is a blind computer specialist who is gainfully employed and has managed to solve his or her transport problem, secure adequate housing and have a family, still disable? An attempt to answer that question will further buttress Montgomery (2006) and Cameron (2008) submission, if environment barrier are reduced or eliminated without much consideration to attitudinal issues, is like attempting to square pegs into round holes.

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