

**CHAPTER 18 (In 'Disability Studies: Past Present and Future' edited by Len Barton and Mike Oliver (1997); Leeds: The Disability Press, pp. 263 - 273).**

## **Defending the Social Model**

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### **INTERNAL ARGUMENT**

Definitive of the disability studies approach is the social model, pioneered by the Union of the Physically Impaired Against Segregation, formalised by Vic Finkelstein (1990) and Mike Olive- (1990), and since codified as the central tenet of the self-organised disability movement, our 'big idea' (Hasler, 1993). In passing, it is important to note that this ideological position should be properly located in British disability politics: the movement in other countries, while adopting a social or minority group approach, have not built their campaign and self-definition around the social model.

Since 1992, however, a range of disabled voices have raised questions and suggested developments which are needed in order to make the model more adequate and more relevant to disabled people's lives (Morris, 1991; French, 1993; Crow, 1996). These critiques have centred on the inclusion of impairment and personal experience within the social model, and have been hotly resisted by other activists and theorists of the movement. For example, Vic Finkelstein (1996) has recently argued strongly and widely that the effect of considering personal experience and impairment is to dilute the effectiveness of the social model. This has to be understood in the context of the historical tendency to explain disabled people's experience with reference to impairment, and the tradition of 'sympathetic biography' (Hunt, 1966).

The current contribution is not intended as a comment on these debates. Our purpose is to suggest that internal differences are actually relatively minor: using examples from academics outside disability studies, we argue that the battle for the social model has by no means been won in the world at large, and that therefore the main priority is to advocate a social analysis of disability, not nit-pick or navel-gaze amongst ourselves. While its details and implications may be contested within the disability movement, there is a broad and vigorous consensus around the social model which should be translated into a renewed attempt to achieve understanding and win acceptance and application of the model within wider society. The views that have to be debunked are not those of other disabled people, but those of the non-disabled academics and commentators who continue to view disability as a personal medical tragedy.

Because of the relative success of the disability movement agenda in achieving coverage in the broadcast media, it is easy to over-estimate acceptance of the civil rights approach in popular thought. The continued focus on medical coverage in both the press and on television is one example of this. Another is the lack of understanding among the (supposedly liberal) press. The opinion columns of the British broadsheets demonstrated this during the campaigns for anti-discrimination legislation in the UK over recent years.

## ACADEMIC RESISTANCE

While it is unsurprising to find establishment broadsheets unwilling or unable to understand and accept the social model and civil rights approach, it is regrettable that other academic disciplines are so slow or unwilling to take account of the recent development of disability studies. It is very common to read texts relevant to disability, which fail even to reference the work of Oliver, Barnes, Morris and others. This ignorance might be expected of various of the medical sciences, to whom the social constructionist approach is a fundamental challenge: however, it is more surprising to find disability studies neglected in other human sciences, and even in other areas of sociology.

The following discussion centres on two approaches to disability: psychology and medical sociology. None is adequate or effective in understanding disabled people's experiences: psychology individualises disability whilst medical sociology pathologises disability. Each contributes insights which are, in a limited way, useful. But none provides a substitute for the social model of disability, to which they are a challenge.

## PSYCHOLOGICAL

A recent paper by Marie Johnston (1996) illustrates some of the problems we have with approaches to disabled people's experiences within psychology. Our critique centres on factors external to her argument (i), and internal to her argument. This second category of criticisms include flaws within her argument on her own terms (ii), and a broader set of flaws arising from her failure to understand the relevance of a social understanding of the disability experience (iii).

(i) On the external point, we would argue that her approach is extraordinarily arrogant, because it relies solely on the psychological literature on disability, not on the perspectives of disabled people themselves. Her approach is to criticise medical models, such as the WHO/OPCS model, and to propose the relevance of psychological explanations. But first she states

The main approach to understanding disability arises from the medical model disabilities occur because of physical impairments which have resulted from the underlying disease or disorder. (Johnston, 1996, p. 205)

We argue that she has taken a reductionist model (WHO) and made it more reductionist, for example by failing to consider what the WHO calls 'handicap' or social disadvantage. Thus she ignores the considerable mainstream social science literature on measuring disability and the debates around the 1988 OPCS Disability Survey.

Moreover, she fails to acknowledge the critique which disabled people and their organisations have made of the WHO/OPCS model (Oliver, 1990; Abberley, 1992). Neither is she familiar with the social model of disability, or the burgeoning disability studies literature: it is neither mentioned, nor referenced. We find this extraordinary, especially in view of the excellent discussion of the psychology of disability developed by Finkelstein & French (1993). While they show the importance of distinguishing between impairment and disability, she chooses to ignore this key point, because it would undermine the basic tenets of her argument, and indeed the approach taken by the discipline of psychology.

(ii) At the outset of her argument, Johnston usefully criticises the linearity of the measurement model proposed by WHO (and implicitly OPCS). Disabled commentators have shown that the scale of severity of disability does not correspond to disabled people's experiences because it ranks non-comparable physical tasks: thus on the OPCS scale, it would be possible to fail the first severity test, but to successfully perform one of the subsequent severity tests, making a nonsense of its testing function.

Johnston adopts a cumulative model of disability, implying a sequential dependence of items, in order to overcome this problem and arrive at an ordinal scale. Thus she argues:

It is not necessary to decide whether failing to get out of bed is worse than failing to walk one mile: those who cannot get out of bed inevitably have a worse level of disability because they are unable to perform the second item. (Johnston, 1996, p. 205)

However, due to her failure to consider the social context in which people experience their impairment, the scale she employs (Williams et al., 1976) is flawed. For example, the scale suggests that a person who fails a higher item must necessarily have failed lower items, because it is intended to be a

cumulative measure. However, while we find item 8, 'Cannot use w .c. or commode without help' may apply to a number of people with quadraplegia, an earlier item, for example item 1, 'cannot use bus or train unaccompanied', might not apply to such persons (given accessible transportation), which means that the scale is neither cumulative nor logical.

This point highlights two problems in Johnston's approach: first, she abstracts on a purely intellectual level, without considering the lived experience and accounts of disabled people. Second, she fails to understand the way in which environment is causally linked to the experience of impairment. In our example, it is because people with quadraplegia could be equipped with suitable power-wheelchairs and could use accessible transport facilities that they would pass item 1, while possibly failing subsequent items.

(iii) Building on the previous two points, we argue that Johnston's failure to acknowledge the social model, and her lack of understanding of disability, are major flaws to the psychological model which she proposes. We will highlight two dimensions of this.

First, she discusses the ways in which disabled people's functional performance can be related to the observations of particular medical personnel, for nurses and physiotherapists respectively. Her argument is that:

the results [differing measures of function by nurses and physiotherapists] may be due to differences in the behaviours elicited by different professions, due to the different expectations in rehabilitation and nursing settings. (Johnston, 1996, p. 207)

Thus she suggests that the attitudes of personnel affect the effort made by disabled people. In one sense, this is useful, because it shows that there are not objective measures of functional loss, but that this is contingent and reliant on context and environment. As a challenge to clinical approaches, this is helpful.

However, Johnston fails to take account of the different ideologies adopted by the relevant health professionals, or indeed the cultural representations of disability. That is, Johnston individualises the relationship between patient and professional, rather than putting the experiences in social context. The result is implicitly to blame the individual, rather than locate the problem in society. A more useful approach would explore the levels of prejudice and stereotyping adopted by particular health professionals, following researchers such as French (1996), Oliver (1996a), Begum (1996) and Abberley (1995).

Further, while it is important to note that the person measuring functional limitation may influence the measurement made, the obvious next stage in the argument would be to draw on the social constructionism of sociologists such as Kitsuse & Cicourel (1963), or indeed Barry Hindess (1973), and suggest that disability (as she defines it) is an artifact of the measuring system used, not an objective outcome (measured either clinically or psychologically). That is, Johnston is correct to suggest that 'the social circumstances influence the level of disability observed' (Johnston, 1996, p. 207), but she fails to draw the right conclusions from her observations.

The second dimension, which is the key point which we want to make, is that Johnston's psychologism is unable to account for the social creation of disability. As our comments on her scaling argument show, it is essential not to reduce the disability experience to an individual or physical can do/can't do model. Disabled people's functional capacities have to be placed in a broader social and environmental context, which can incorporate issues such as disabling barriers, availability of aids and personal assistance, and financial and material factors. Rather than adopt the normalising and pathologising perspective of Johnston, psychology must accept that people with impairment manage their physical issues in various ways, but that the key problems they encounter are prejudice and discrimination (physical and social barriers).

To conclude this discussion of Johnston's approach to the construction of disability, we wish to make two key points. First, following Finkelstein & French (1993), we acknowledge that psychological arguments do have relevance to disabled people's experience. Disability studies needs to pay attention to the distress caused by people's experience of social disablement (Keith, 1996), and indeed it has been argued that we need also to explore the impact of impairment itself (Crow, 1996). However, in order to adequately understand these issues, it is vital to start by distinguishing between impairment and disability, and to remove the causal reductionism of which both psychologists such as Johnston, and biomedical clinicians are guilty.

If, like Johnston, we fail either to distinguish impairment and disability, or to take a social model perspective, then the consequence is clear. Rather than moving forward from the limitations of the WHO/clinical model, we are left with a clinical/ psychological model which continues to individualise disability, but also is guilty of 'blaming the victim'. This is because the model attributes disabled people's rehabilitative progress to their motivation or general psychological state, rather than the social context in which they find themselves, or indeed their willingness or otherwise to accept the normalising values of the rehabilitation approach. While it would be incorrect to suggest that motivation or psychological state is irrelevant to rehabilitation, or indeed

to other dimensions of the disability experience, it is extremely dangerous to give primacy to such victim-blaming and value laden approaches.

## SOCIOLOGY OF MEDICINE

Medical sociology is another discipline that appears to have problems accepting or working within the social model: emphasis is placed squarely on the experience of chronic illness and disability, individualising the experience. The analysis is couched in terms of coping, adaption, identity and how individuals make sense of and come to terms with their impairments and disablement. Two recent papers by Ruth Pinder (1995, 1996) exemplify this approach. In both these papers she uses detailed case studies of two people with arthritis, examining their experiences of managing, or not managing, in the work force.

Each paper analyses the experiences of two informants; one who is able to continue working and one who is forced to give up work. Pinder's sole project appears to be an attack on the social model of disability. Unlike Johnston she does acknowledge the existence of this model, but does so in disparaging terms. Whilst recognising, and sympathising with this approach she feels it provides only a 'limited understanding' (1996, p. 137). Many working within disability studies will have been angered by the tone of these papers. This is unfortunate, because expressed within a less jaundiced account, the interesting aspects of her research would have been better communicated.

An unprejudiced assessment of recent developments in the field of disability would have included two major points. First, the self-organised movement of disabled people, and the social model theory with which this political development is associated, has had a major impact on British society, as elsewhere in the world. Liberal and individualistic analyses and policy interventions have for years failed to make much impact on the problems of disabled people. However, the radicalism disavowed by Pinder has had an incontrovertible effect, resulting in both social improvements and individual empowerment. The proof of the pudding is in the eating, and despite Pinder's hostility, the social model has brought major benefits to disabled people (which does not mean it is not an over-egged pudding). Obviously individual disabled people may not always agree with the radical agenda or analysis, just as individual women have often not supported feminism. But this does not mean that disabled activists, any more than feminists, are wrong.

Second, the social model of disability is in a process of development, exploration and analysis. While Pinder presents a picture of stone-faced ideologues misrepresenting disabled people's lives, in fact we have thousands

of disabled people, including academics, discussing the issues and arguing about the best way to theorise disability. As well as the papers by Crow and French which Pinder references, there is published work by Morris (1991) and Shakespeare (1992), and unpublished work and unrecorded debate by many others. As with any other area of political debate, or sociological theory, there is a constant process of criticism, self-criticism and development (Oliver, 1996b). The social model originally underplayed the importance of impairment in disabled people's lives, in order to develop a strong argument about social structures and social processes. No theory emerges into the world fully formed, and getting the balance between the experience of impairment, and the experience of disability is a continuing endeavour. Pinder's analysis elsewhere in her paper will actually contribute to this process, and should be welcomed.

As well as these omissions, there is a misrepresentation of the body of work which Pinder refers to as 'disability theory' and which is commonly described as 'disability studies'. Pinder suggests a neglect of what she calls society's 'sins of commission', and describes discrimination in terms of negative attitudes. In her conclusions she refers to cultural proscription, marginalisation of outsiders and other social processes which she argues are not dealt with within the social model approach. She is entirely right to identify aspects of cultural representation and social attitudes, which are extremely disabling for people with impairment.

However, far from offering an original analysis, or locating a lacuna within disability studies, she is in fact making an old argument. For example, Paul Hunt discussed such processes in 1966. Jenny Morris described the effects of prejudice in 1991. David Hevey developed a substantial theoretical account in *The Creatures Time Forgot* (1992). Colin Barnes summarised the key issues in 1992. Shakespeare (1994) subsequently published an article which explored cultural representation and theorised prejudice, using the concepts such as anomaly and liminality to which Pinder refers in the current paper. Many other contemporary sociologists within disability studies are exploring the body, impairment, and cultural processes (Barnes, 1995; Shakespeare & Watson, 1995; Oliver, 1996b). Equally, her suggestion that we need to explore closely the relationship between impairment, environment, and social interaction in the employment context has already been acted on by Alan Roulstone (1993) and forms the subject of his forthcoming monograph.

In order to grind her particular axe, Pinder has constructed a picture of the disability studies perspective which few would recognise, and reinforced it by reference to a mere two research informants. Her critique is out-of-date,

skewed by her biography, and highly subjective. Pinder's paper, despite numerous merits and points of interest, represents a cul-de-sac.

## MOVING ON

We have tried to demonstrate how the social model has had a limited impact, both in the mainstream media, and academic discourses other than disability studies. This failure relates to the ways in which other literature either ignores disability, or misconstrue disabled people's lives. While this may be expected within biomedical and clinical approaches, its prevalence within social sciences should give cause for concern.

What lessons can be learnt from exploring the range of reactions (and non-reactions) to the social model of disability? It could be argued that the continuing ignorance and hostility outside the movement highlights the danger of internal dissension. It has been suggested that questioning, for example the role of impairment, provides a 'hostage to fortune' and that alternative views should be suppressed, in order for the movement to speak with one, social model, voice (Finkelstein, 1996). Often, the disability movement prioritises marching to the beat of a single drum, favouring a united line to competing voices.

Our conclusion is different. We have consistently argued that pluralism is a positive value, within both the disability movement and disability studies. Debates are necessary, and recognising difference within the disability community is overdue. Neither does openness threaten the central political goals of the movement. Post-modernist writers have argued against 'meta-historical narratives' and the modernist pursuit of universalising and monolithic rationality (Fraser & Nicholson, 1990), and the contemporary experiences of disabled people highlight the value of such critiques. From this perspective, those who develop and refine the social model ensure its renewal and continuing relevance. Particularly, the dominant version of the social model has favoured a materialist, if not marxist, worldview. We argue it is possible (and indeed desirable), to retain the social model within a more nuanced worldview drawing on feminist and post-modernist accounts.

However, it is critical to have clarity about the wider intellectual environment. The differences within the movement on the issue of the social model are as nothing when compared to the hostility and ignorance with which the social model is greeted in the wider world. We suggest, therefore, that while academics and activists can debate amongst ourselves, our main efforts must be to fight for a social model analysis in



society as a whole, and to take the insights and evidence we have gathered into other disciplines and areas of public discussion. Rather than putting energy into internal arguments, we need to challenge the continuing complacency of the intellectual establishment, and to win the battle for a social model understanding of society and our lives.

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