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Understanding Models Necessary to Treat Disability Issues

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ABSTRACT

Working for the disabled is a herculean task and requires relevant models to enhance intervention. Models are needed to guarantee efficient and effective services to the disabled. It is no gainsaying that models of disability provide insight into people's attitudes, perceptions and prejudices on disability and how these impact on the wellbeing of the disabled. Essentially, models reveal the extent to which the society provides access to work, education, economic empowerment and others to the disabled. Basically, two philosophies govern the use of models in working for the disabled. The first philosophy sees disabled people as dependent upon the society. The philosophy encourages paternalism, segregation and discrimination. The second philosophy perceives disability as consequences of negative attitudes of society. This philosophy advocates preference, empowerment, equality of human rights, and integration. The study aimed to examine extent to which each philosophy influences the use of models in treating disability issues as well as note the more frequently used models.

KEYWORDS : paternalism, disability, models, human rights

Introduction:

Studies suggest that there are about 500 million disabled people in the world population and out of this, 80 percent of them live in the developing world (Swain & French 2004). The main causes of the impairments include poverty, inadequate sanitation, malnutrition, poor water supply, and more recently HIV and AIDS. Researchers have successfully used several models to study the disabled. Models of Disability are tools developed to define impairment and strategies to meet the needs of disabled persons. Researchers like Altman, (2001), Asch, (2006) and Johnson,(2003) believe that providing services to the disabled without a model is incomplete and will encourage narrow thinking and lack of detailed guidance in the use of interventions that benefit the disabled. Models are useful framework that assist health workers to understand disability issues, and interventions to alleviate the problems of disabled persons.

Studies by Engel, (1977), Goodley, (2001), Zola, (1989), and Shakespeare, (2006) suggest that models should not be seen as exclusive options where one will be termed as superior or replacing the other. The development and popularity of each model should be seen as a continuum for changing social attitudes toward disability. However, models change as society changes. Disabled people spend countless hours learning to walk or talk at the expense of their education and leisure (Oliver 1996). With this understanding, the objective of working for the disabled is to develop and operate a cluster of models that are capable of empowering them with full and equal rights as others in the society.

For this study, the models to be considered will include: The medical model of disability, the social model of disability, the professional model of disability, the tragedy and/or charity model of disability, the moral model of disability, and others. Efforts will be made to present the practical applications of each model in health service interventions.

Methodology:

Information gathered in this study was through extensive literature review.

The Medical Model of Disability:

The *medical model* is regarded as an individual model of disability, a part of the disease process, an abnormality, and an unfortunate individual tragedy that happens on random basis. Studies have shown that the most dominant model of disability is the *individual mode* which assumes that the difficulties disabled people experience are as a result of their physical, sensory, or intellectual impairments (Oliver & Sapey 2006). The medical model believes that problems must be overcome by the individual's efforts since the problems reside within the individual (French 2004). In this model, if the blind person falls down as a result of the obstacle in the room he or she does so because he or she cannot see the obstacle. Also if a person with motor impairment fails to move into a building he or she does so because of his or her inability to walk. Here problems are viewed as inherent *in* the individual. Barnes and Mercer (1996) argue that the individual model of disability should focus exclusively on attempts to modify people's impairments and return them to "normal." Therefore, that the effects of the physical, attitudinal, and social environments of the disabled people should be regarded as fixed. This thinking has kept disabled people in disadvantaged state because of their inability to address their problems in the society (Oliver & Sapey 2006).

Because the medical model of disability views disability as the problem of an individual caused by disease, trauma, or other health conditions, sustained medical care to be provided by health care professionals constitutes the main intervention needed. The main objective is to enhance the management of disability by providing a "cure." This means providing the individual with adjustment and behavioral changes that would lead to "almost-cure" or effective cure. At the political level, the response is geared towards modifying or reforming healthcare policy that would benefit the disabled. Using the medical model and viewing disability as an individual problem show that if someone has impairments such as visual, mobility or hearing impairments, the person's inability to see, walk or hear is understood as the disability. This is why the medical model is sometimes regarded as the 'personal tragedy model because the model regards the way in which the body is shaped as responsible for the difficulties people with impairments experience.

In medical model , disability is regarded as a result of an individual's physical or mental limitations which is unconnected to the social or geographical environments of the individual. This is why disability is referred to as "Biological-Inferiority" or" Functional-Limitation". Using this model, the World Health Organisation (WHO 1980) differentiated between impairment, disability and handicap. Impairment is termed as loss of the psychological, physiological or anatomical structure or function, while disability is restriction or lack, resulting from impairment which gives rise to inability to perform an activity in the manner or within the range considered normal for a human being. Handicap is ***a*** disadvantage resulting from an impairment or disability that prevents a person's fulfillment of a normal role by age, sex, social and cultural factors. This definition of handicap, according to Gliedman, and Roth, (1980), is at variance with the belief of the disabled people. The disabled people believe that in the absence of cure for physical conditions, that the impairment must be lived with. It follows from this that any negative interaction between the disabled and the non-disabled must be overcome by restructuring the social and physical environments. Therefore, WHO in relating the consequences of diseases describes issues of disability by emphasizing the experiences of individuals with particular impairments in their social and physical environments. This is why compensatory services are exclusively provided to people with impairments just to compensate them for the malfunctioning of their bodies. This contributes to the common view of the disabled that their problems stem from malfunctioning bodies. And as such,

that their impairments automatically prevent them from taking part in social activities. This thinking is part of what makes the disabled

not to challenge their exclusion from mainstream society (Darke, 2004, Swain, and Sally 2004, Oliver, & Sapey 2006).

In the Medical Model, the first step to a solution is to find a cure or - to make the disabled "normal" (WHO,1980). Studies have shown that mere treatment alone cannot solve the problem of disability but rather, to accept the "abnormality" and seek the necessary care and support for the "incurable" impairment. It is on this premise that policy makers provide service options like rehabilitation, vocational training for employment, income maintenance programs and the provision of aids and equipment to the disabled (Stone, 1997, Tremain, 2001& Terzi, 2004). Although the medical model emphasizes cure to alleviate the physical and mental conditions of many disabled people, but cure alone does not offer a realistic approach because most disabled persons reject the idea of being seen as "abnormal" (Goering, 2008). Concentrating on cure as the main problem solving technique provides justification for institutionalization and segregation which restrict the disabled from controlling their lives and developing their potentials.
Therefore, medical model introduces prejudice in the minds of employers. Employers are reluctant to engage the services of disabled persons because of the thought that a disabled person will be ipso facto prone to constant ill health and sick leave, thereby be less productive than other work colleagues. As a result, employers discriminate by engaging more the services of non-disabled people than that of the disabled.

The Social Model of Disability:
The negative attitudes meted to the disabled as a result of cultural differences gave rise to the development of social model (Ingstad and Reynolds Whyte 1995). The model examined the ways in which the body and the physical characteristics of a disabled person give value and meaning. As a result, the social model of disability sees the issue of "disability" as a socially created problem where the disabled persons are denied full integration into the society. In this model, disability is regarded as a complex collection of conditions, which are created by the social environment. For this reason, management of the problems of the disabled requires social action and collective responsibility of the society to make the environment conducive for them to participate in social life. Therefore, intervention using the social model needs both cultural and ideological issues to initiate social change and conducive environment.

Proponents of social model believe that disability is a social oppression where society intentionally puts barriers (attitudinal, environmental and organisational) to prevent disabled people from having equal opportunity in accessing social services (education, employment, housing and transport) like others. These barriers lead to discrimination and removal of the discrimination requires change in the way society is organized. **Using the social model, it is believed that the society needs to change its negative attitude toward the disabled and allow the disabled the right to function in the society. There are two main concepts in this model. First is that impairment is part of an individual and second, that disability is the problem of the society and not that of the disabled.**

Social model presents a complex and controversial picture of disability in both developed and developing countries by analyzing the cultural diversity and commonalities of disability in various ways. While developed countries provide welfare schemes to the disabled, others do not (Flood 2005; Sheldon 2005). Notwithstanding the cultural differences, commonality is an overriding picture in disability (Hughes 2002). Commonality is engendered by multiple deprivations which result to poverty. Social model views the disabled as the poorest of the poor in any society. However, disabled people are relatively poor in the developed world and absolutely poor in the developing world (Stone 1999).

The establishment of Disabled Peoples' International (DPI), is an expression and realization of commonality which represents disabled individuals with different types of impairments. The objective of DPI is to ensure that the voice of disabled people is heard in the development of all policies and programs that directly affect them, hence the slogan "Nothing about Us without Us". It also ensures that the human rights of disabled people are respected and implemented. Social model emphasizes the establishment of full citizenship for disabled people. The problem is that the " individual model" or" medical model" has dominated research on disability. This dominance has produced negative impacts in the assessments of disabled people's quality of life (Hurst, 2003 &Barnes 2004). The belief is that the disabled people create their "problems," and not the disabling society. This is why methodological approaches for carrying out research on disability issues are now controlled by disabled people themselves and subsumed under the term *emancipatory research* (Barnes 2004). In terms of social policy, the social model is evident in the establishment of civil and human rights-based policy for the disabled. One clear advantage of the social model is that it promotes social change by encouraging *independent living* (Barnes and Mercer 2006).

The social model was developed to remove barriers which the society artificially created for the disabled. For example if an individual is using a wheelchair as a result of mobility impairment, the individual is not regarded as disabled in an environment where the individual can use public transport and gain full access to a building and its facilities in the same way that someone without the same type of impairment would do. By so doing, the disabled would have the opportunity to determine his or her own life styles like everyone else.

Therefore, the aim of social model of disability is to create positive changes in the way people view disability, as well as to make positive impact on anti-discriminatory policy.

The Expert or Professional Model of Disability:
Professional model of disability is a derivative of the medical model which concentrates on identifying impairments and their limitations by using the medical model, and taking necessary action to improve the health of the disabled person. Professional model produces a system where an active health care service provider prescribes and acts for a passive client. This is why the professional model of disability is described as the " fixer (the professional) and fixee (the client)" technique thereby introduce inequality and no collaboration.

The problem is that the professional's caring method encourages imposition of solutions that are not benevolent enough as to maintain the client's dignity (Menzel,1992, Nordenfelt, 1997, Scotch, & Schriner, 1997). Using this model, the "expert" makes all the decisions and the client accepts and adheres to the decisions made. This makes the client unable to exercise his or her human right freedom of choice. In the end, the client's dignity and the opportunity to participate in basic daily activities that affect life are undermined.

The Tragedy and/or Charity Model of Disability:
The charity model of disability sees the disabled as victims of negative circumstances in the environment who should be pitied. The charity model and the medical model are commonly used by non-disabled people to define and explain disability issues. Charity model is used by charity organizations in fund-raising business. The application of the tragedy/charity model is illustrated when charity organizations televise children in need and care when appealing for funds. The children are televised, and appeals made for their support, to attract sympathy and encourage charitable individuals to donate resources for the upkeep of the children. The appeals help to raise substantial funds to augment the services which governments rarely provide. Studies have shown that many disabled people do not encourage this model. They regard the model as very offensive because it shows disability as negative victim-image. Disabled persons argue that children in need should not be presented as "televisual garbage" to avoid discrimination (Oliver,1990, & Putnam, 1995). Some authors interpret the charity model as a ploy the non-disabled people use to sustain flow of donations to guarantee their work. Therefore, charity model has been described as the "tragic portrayal" of disability (Shakespeare, 2006).

Critics have condemned the use of charity model in treating disability issues arguing that the model causes much discrimination against the disabled. Some authors feel that the biggest problem of the disabled is the idea of the non-disabled viewing them as icons of pity in need of care and support . Thereby regard the disabled as unable to manage their own affairs, and therefore must need charity in order to survive. This view gave rise to tragedy and pity in the

concept of "care" (Wasserman, 2001, & Darke, 2004).

While the tragedy and/ charity model could be commended for assisting in raising resources to care for the disabled persons, it has some disadvantages. The fact that numerous charity organizations support and care for people with different types of disability, and also medically classify them according to their disabilities help to encourage their segregation. The problem is that after segregation, the next stage is to initiates institutionalization of the disabled people. Institutionalization further encourages discrimination of the disabled (Oliver,1990, Barnes, 2004, French, 2004). Given the choice, many disabled persons , would opt for community life to avoid discrimination and charity giving. The disabled disapprove charity giving because it imposes gifts , limits choices, expects gratitude from the beneficiaries, thereby lower beneficiaries self-esteem (French, 2004, James, 2000). The problem is that employers regard disabled people as charitable cases that do not need employment. As a result, employers conclude that making charitable donations will meet social and economic obligations of the disabled persons more than employing them (Barnes, 2004).

However, charitable acts, and caring that bring in some funds to maintain the disabled should not be discouraged. There is need to encourage charity organizations and professionals to review the way they manage donated funds so as to ensure that the funds are channeled towards empowerment and full integration of the disabled into the society. This could make people see the disabled as individuals who require empowerment and not pity.

The Moral Model of Disability:

Moral model believes that individuals are morally responsible for their disability. The model views disability as a result of indulging in bad behaviours and attitudes. This view is represented by the doctrine of "karma" in Indian religion, which is,"what you sow is what you reap".

From religious point of view, disability is seen as punishment inflicted by spiritual force as a result of misdemeanors committed by either the disabled person or someone in the family or community group. Also congenital disorders are regarded as negative actions committed in the previous reincarnation. Using this model, disability is seen as caused by the evil spirits, the devil, witchcraft or God's displeasure. In this situation, exorcism and sacrifice are performed to placate the negative influences of the evil spirit. Exorcisms, rituals, providing care, promoting cure, donations and hospitality are termed as the duty of Christians to the needy(Barnes, & Mercer 2006).

Historically, moral model is the oldest but the least prevalently used because many cultures associate disability with sin and shame, and as a result, disabled persons often develop feelings of guilt . The fact that the model associates shame to families with a disabled person, such families tend to hid the disabled from public view (Oliver, 1996). The family members now keep their disabled person(s) out of school, social gatherings thereby, deny them the opportunity of having meaningful roles in the society. In many circumstances, using this model has resulted in general social ostracism and self-hatred for the disabled (Ingstad, & Whyte. 1995, Stone, 1999, Goggin, & Newell, 2003).

The empowering Model of Disability:

The empowering model of disability allows the disabled person and his/her family to decide the type of treatment and services they wish to benefit from. This gives the disabled and family members the opportunity to choose the type of services they desire from the health care professionals. Using this model, the health care professional is regarded as a service provider whose role is to offer guidance and carry out the client's decisions. In other words, using this model empowers the client to contribute and execute his/her own goals (Boorse, 2010 & Brock, 2005). Here, the professional is a service provider to the disabled client and his or her family. The client and family members will decide and select the types of services they believe will be needed unlike what is obtainable in the expert model .

The Economic Model of Disability:

The economic model of disability describes a person who is unable to participate in work as a disabled person. The model assesses the extent to which impairment affects an individual's productivity and the economic generating potentials. The model evaluates the ability of the disabled person to live independent life. It examines the consequences of the disabled losing earnings opportunities (Basnett, 2001, & Zola, 1989). Economic model is used primarily by policy makers to assess the extent to which those who are unable to participate fully in work enjoy work benefits. The emphasis of the model is on productivity (Brisenden, 1986).

The major challenge of the economic model is how to justify and support in economic terms, the social policy of increasing participation in employment. According to classical economic laws of supply and demand, an increase in the labor market results in decreased wages. Arguably, access to work through equal opportunities reduces an employer's labor costs, but the value of labor is based upon its contribution to marginal cost which corresponds to the cost of producing the last unit of production. This works when employees make equal contribution to the marginal cost. However, evidence has shown that disabled employees make lower contribution than their non-disabled work colleagues resulting in losses in production and profits for the employer (Barnes, & Mercer. 2006, Harpur, & Bales, 2012).

Another problem of economic model is the choice of whether to employ the disabled and pay them less for operational ineffectiveness, or to refrain from employing them for fear of likely loss of productivity. The first option will stigmatize the disabled person by underestimating and comparing their work performance with that of their non-disabled work colleagues. With the second option, employers may have difficulties in assessing the correct level to pay the disabled. However, a situation may arise where productivity and marginal costs of the total workforce of a disabled employee may increase. This leaves the difficulty of how to achieve an equitable, effective, value-for-money benefits of the disabled employee. It is likely that the productivity levels of some employed disabled persons may be high while others may be low. To the group with low productivity they could be termed as unemployable in economic terms. They are the group employers are reluctant to engage their services. To this group, other sources of supporting them without introducing stigmatization should be adopted. There is need to balance equity (the right to self-fulfillment and social participation through work) and efficiency. This constitutes the true value of the use of the economic model of disability.

The market Model of Disability:

The market model of disability recognizes people with disabilities as Stakeholders of consumers and employees in the society. The model looks at the ability of each disabled person to cope with daily life activities. The model encourages people with disabilities to focus on economic empowerment as the only sure means of survival. Using this model, family members, friends and employers are considered as Stakeholders in disability issues. The model is of the view that since the society has large numbers of companies, establishments and government agencies, that they should serve as avenues for employing the disabled persons. Employing the disabled persons will help to meet their social, psychological and economic needs and reduce their dependency on others (Goggin, & Newell. 2003, & Darke, 2004).

The Spectrum Model of Disability:

The spectrum model refers to the range of visible, audible and sensible functions of the body. The model asserts that disability does not mean reduced spectrum of body operations. It argues that one can be disabled and yet perform all functions maximally. This means that disability is not a limitation to the performance of assigned individual roles.

Rehabilitation Model of Disability:

Rehabilitation model of disability is an offshoot of the medical model, which views disability as a deficiency that must be treated by a health care professional especially rehabilitation professional. This model regards the disabled as someone in need of rehabilitation services like vocational training, treatment, counseling and others so as to cope with deficiencies caused by the disability. Rehabilitation model was introduced after the World War II when it became necessary to reintegrate the disabled veterans into the society.

Using this model, the disabled are exposed to both the medical and the rehabilitation models of disability. While medical intervention may be required by the disabled at times, medical services alone may not be the appropriate focus for handling disability related policy matters. This is because many medical conditions that result to

disabilities may not be completely cured by medical treatment . Persons with disabilities need rehabilitation services to integrated them actively into the society. The model sees the disabled as persons in need of medical, social , psychological and vocational rehabilitations for a holistic reintegration into the society. The model discourages Institutionalization and confinement of the disabled persons arguing that such would limit their integration in the society but rather, suggests community services as a better option (Harpur, 2013).

Right-based Model of Disability

Right-based model conceptualizes disability as a socio-political construct. The model emphasizes independence for the disabled. It advocates active political voice for the disabled even though social forces favour the non-disabled (ableism) more than the disabled'. The model encourages the disabled to seek both elected and appointed positions like others in the society. The premise is that the disabled if given equal opportunities like others in the society coud perform as creditably as others, if not more than others.

Conclusion

There are a number of 'models of disability which have been successfully used to treat disability issues, but the two most frequently used are the 'social' and the 'medical' models of disability. The medical model sees the body as machine which requires fixing in order to conform with normal functions. The social model identifies exclusion of the disabled from social activities as the main contributory factor in disabling people. According to social model of disability, physical, sensory, intellectual, or psychological deviations may cause functional limitations or impairments, but not disability

The distinction between biological impairment and social limitation is relevant in deciding the type of model needed to address disability issues especially selecting the appropriate model that would modify the disabled persons' conditions as well as alter the environment for favorable coexistence. In this paper attempts were made to highlight the distinctive roles the service providers, members of the society and the disabled persons would play to address the myriad problems that critically affect the subsistence of the disabled persons. The paper showed the commonalities in each model and how the models compliment each others' efforts in addressing disability issues. The paper highlights the incredible variation in the ways the disabled persons experience stigmatization and discrimination as a result of structural or functional atypicalities. Therefore, for efficient and effective intervention of disabled issues, appropriate models should be used during such interventions.

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