



CHAPTER TWO

DISABILITY MODELS

As a wheelchair user who had polio when I was young, I have experienced well-meaning individuals tell me that if I just pray and live my life as God wishes me to, I will be cured, the implication being that I must not be living a “Godly” life since I still need a wheelchair for mobility. These beliefs are a good example that the moral model continues to guide people’s thinking.

—Nancy, faculty member

Most disability models are closer to paradigms than they are to theories in that they present a certain way of viewing disability based on people’s perceptions, beliefs, and experiences rather than research data. Definitions and conceptualizations of disability presented in models reflect the worldview of specific time periods and cultures (Drum, 2009). As such, disability is a social construction, the meaning of which shifts over time and place and is influenced by political ideology, economic conditions, and cultural values (Meade & Serlin, 2006; Olkin, 1999). Olkin (1999) explained that “each [model] has a perspective on what ‘the problem’ of disability is, who holds the problem, and avenues that best address the problem” (p. 24). How U.S. society has perceived disability over the course of the country’s existence has provided the foundation for how individuals with disabilities have been viewed and treated, as well as the expectations and assumptions held by individuals with disabilities themselves.

Interactions between individuals with disabilities and various societal institutions, including the family, community, workplace, and educational system, are dictated largely by the meaning that society attaches to disability during

a specific period in history. Different assumptions about disability—that is, disability models—have influenced whether individuals with various disabilities were able to attend college at specific times during the history of the United States and their experiences after they enrolled. Scholars have also based research on specific models to verify the ideas they include.

In this chapter, we first review the moral, medical, functional limitations, social, and minority models as major disability perspectives that have guided thinking and action over time. We discuss them in the order in which they became important in society, noting factors that were influential in their development. We then outline critical disability theory and critical realism as two models that have influenced our thinking and have potential to contribute to the understanding and practice of disability scholarship and disability support. We next highlight the social justice model, which we believe has particular utility in higher education settings. Then we briefly discuss two emerging models, the disability justice model and the interactionist model, that introduce useful ideas not found in other models. The appendix at the end of this chapter summarizes key points of the models we describe. Older models do not disappear when new models arise. Many of these models coexist in society currently, and there are still vestiges of the earlier models, as Nancy's experience discussed at the start of the chapter demonstrates.

While disability models vary greatly in how they conceptualize disability, Scambler and Scambler (2010) posited that a theme connecting diverse perspectives is the idea of chronic illnesses and disabilities as “assaults on the lifeworld” (p. 1). This broad understanding of disability allows for a variety of disability models, each of which interprets the contributions of biological, psychological, and social factors in its own way. Disagreement over disability policy, legislation, and practice can be attributed to differences in how disability is defined and conceptualized by individuals using different disability models (Scotch, 2009). Understanding the principles associated with each of the major models is therefore necessary prior to exploring how disability is understood and addressed in higher education.

Established Models

We begin by providing overviews of established models of disability that have guided understanding of disability since the start of the Common Era (moral model), the 19th century (medical model), the beginning of the 20th century (functional limitations model), and the 1960s and 1970s (social model and minority group model).

Moral Model

Proponents of the moral model view “disability [as] a defect caused by moral lapse or sins” (Olkin, 1999, p. 25). As early as the beginning of the Common Era, the Jewish culture linked physical defects to the “sins” committed by individuals and believed that it was up to individuals to cure themselves since their actions had caused the defects (Stiker, 1999). During medieval times when religious beliefs and practices dominated the thinking and actions of Western civilization, people believed that disability was God’s punishment for “sin, failure of faith, moral lapse, or evil” (Olkin, 1999, p. 25) committed by individuals themselves or members of their families. Physical impairments could also be “the work of the devil” (Drum, 2009, p. 27). Because they were viewed as the result of the individual’s moral misbehavior, defects brought shame on the individual and the family (Olkin, 1999). As a result, during the Middle Ages, people who were viewed as defective were “shunned, condemned, or used for entertainment purposes, e.g. as court jesters” (Drum, 2009, p. 27).

During the late 1800s, disability and its related effects, such as poverty, unemployment, and dependence on others, continued to be viewed as a result of fate, God’s punishment, or individual moral weaknesses (K. W. Hickel, 2001). Because disabled people were viewed as weak, flawed, and having brought their conditions on themselves, government agencies as well as private charities refused to provide aid to adults disabled in later life, although they did assist children with disabilities and veterans of military service (K. W. Hickel, 2001).

While the moral model is not the most prevalent view of disability today, vestiges of it remain in today’s language, culture, and beliefs (Olkin, 1999). For instance, one often hears the phrase, “It is God’s will,” when a child is born with an incurable illness or a person becomes paralyzed as a result of an automobile accident. Western culture is permeated with the belief that disability is “bad” and, as a result, individuals with physical and mental impairments must have done something “wrong” that contributed to their condition. This attitude is especially evident when individuals are viewed as having played a direct role in their impairment, such as those with AIDS, Type 2 diabetes, obesity, or addictions. In such cases, it is viewed as acceptable to blame these individuals for their disabilities and even to exclude them from protection under the Americans With Disabilities Act Amendments Act (ADAAA; e.g., those with drug addiction who have not stopped using drugs). In addition, pop culture (e.g., television programs, movies, and popular books) often portrays disabled characters as villains or evil persons (Longmore, 2003). Arguments against providing government assistance to people with disabilities are frequently based on similar thinking (Shapiro, 1993).

Olkin (1999) provided another viewpoint originating from the moral model: “the myth of disability as mysticism” (p. 25). This belief suggests that when individuals lose one of their senses, other senses are heightened, such as the blind seer in the ancient Greek play *Oedipus* who provided the king with a prophecy regarding the future. Similarly, some people believe that as a result of surviving the adversity of living with a physical impairment, individuals will develop special spiritual, emotional, or reflective powers (Olkin, 1999).

Medical Model

Many factors converged during the mid-1800s that led to the development of the medical model. Most important was the beginning of the scientific and medical fields during the late 1700s and their refinement throughout the 1800s (Castañeda, Hopkins, & Peters, 2013). A second factor was the emergence of the concept of the “average man” whose characteristics and qualities were assumed to be “correct” or “normal” (L. J. Davis, 2006, p. 6). Any deviation from the average was viewed as deviant, abnormal, and in need of correction in order for a person to be acceptable in society. In addition, scientific advances during the 1800s led to a better understanding of diseases and their causes (Drum, 2009). Thus, by the late 1800s, disability was considered a public health issue, and people came to believe that it could be treated by physicians in institutions designed for that purpose (Drum, 2009). By the early 20th century, social service agencies, educational institutions, health care personnel, and policymakers formalized the medical model of disability and placed disability under the authority of medical and quasi-medical professionals (Nielsen, 2012). From these beginnings, the medical model evolved and remains a major paradigm for understanding, treating, and working with people with disabilities. A number of variations of the medical model exist (see Altman, 2001; Masala & Petretto, 2008); our overview focuses on principles associated with the majority of these approaches.

Adherents of the medical model view disability as “a medical problem that resides in the individual ... a defect in or failure of a bodily system and as such is inherently abnormal and pathological” (Olkin, 1999, p. 26). If the person is to fully function as a human being, this defect must be “cured or eliminated” (Siebers, 2008, p. 3). Fine and Asch (1988/2000) listed the following assumptions of the medical model: (a) disability is located only in the body, (b) a person’s problems are caused by the person’s impairment, (c) disabled persons are “victims” who must learn to handle the circumstances they face, (d) how disabled persons view themselves and compare themselves to others

centers around their disabilities, and (e) people who have disabilities need help and support.

The medical model is linear (Minaire, 1992). Disabilities are caused by diseases, illnesses, traumas, or internal biological conditions (Drum, 2009) that create pathologies defined as physiological or cognitive impairments that make persons different from those who are considered “normal” (Meade & Serlin, 2006). The resulting symptomologies are the limitations people experience in their ability to perform everyday activities people of a similar age can complete, such as personal self-care, attending school, managing a household, or maintaining employment (Longmore & Umansky, 2001). Thus, users of the model focus “on the disease process itself, with the goal of curing the disease and returning the patient to normal functioning” (Lutz & Bowers, 2003/2007, p. 13). Therefore, a university’s disability resource office staff using a medical perspective would focus on students’ access to appropriate health care.

Rather than viewing individuals with disabilities as people, adherents of the medical model see them as “social embodiments of their physical disability: they are dysfunctional or quasi-functional or nonfunctional bodies to be repaired or, if not, then managed with bureaucratic and economic efficiency” (Meade & Serlin, 2006, p. 3). It is up to the medical professional to decide how to cure the disabled person’s problem and the disabled person must do exactly what is prescribed in order to “get well” (Pfeiffer, 2000/2007, p. 7), taking on what Parsons (1951) labeled the “sick role” (p. 23). By taking on the sick role, individuals do not have the same social obligations as others in society, such as employment or household management, because they are “sick,” but they also give up their rights to those who are caring for them (Pfeiffer, 2000/2007). If they do not obey the regimen prescribed by their physician or are not “cured” of their illness, they must accept the blame for their failure “to respond to treatment” (Drum, 2009, p. 28). Scambler and Scambler (2010) observed that under the medical model, the lives of individuals with disabilities can be affected as much by fears of stigmatization as by the direct effects of the exclusion from society they experience as a result of being excused from their social responsibilities.

A number of critiques of the medical model can be found in the literature. Imrie (1997) noted that focusing exclusively on the biological aspects of disability ignores factors such as culture, environment, and politics that play an important role in disability and its effects on individuals directly and by way of the attitudes and prejudice that result from these aspects of society. Lutz and Bowers (2003/2007) also suggested that while the medical model can be useful in the diagnosis and initial treatment of diseases, it does not take into consideration other factors that affect individuals with disabilities over the course

of their life span. Psychologists have also expressed concern that the medical model does not take into consideration that psychological distress from prejudice and discrimination can contribute to how individuals experience and respond to disability (Marks, 1997). Disability activists reject the idea of equating disability with illness or abnormality. Many find the views and resulting treatment disabled people receive from members of the medical community as oppressive and marginalizing (Bricher, 2000).

Strict adherents of the medical model, who are concerned only with curing the illnesses or physiological abnormalities exhibited by individuals with impairments, are most likely to view disabled individuals as unfit to attend college or work in any capacity. One of the reviewers of a draft of this book (M. Peña, personal communication, August 5, 2016) shared an experience that she had with this type of thinking when she began working at a college in 1989: “I had to go before the college board, introduce myself, and talk about my college degrees, [and] then proceeded to tell them about my learning disability. One of the board members said, ‘Having a learning disability and going to college are mutually exclusive.’” Since they are viewed as being sick, disabled people are considered unfit to take part in the normal activities expected of a college student or employee.

Within the medical model, there is no expectation that society will make adjustments to change people’s attitudes or improve the environment so that people with disabilities can participate fully. People with disabilities are expected to rely on medical intervention, such as medication, therapy, or other forms of treatment, to address the symptoms and problems associated with their impairment. Another experience that our reviewer, M. Peña (personal communication, August 5, 2016), recalled was an employer who, upon learning that she had a learning disability, asked her if she took a pill for that. Those who adhere to the medical model also believe that if there is no current intervention to treat the impairments of disabled individuals, they must adjust to being outsiders and wait for a cure for their ailment.

Functional Limitations (Rehabilitation) Model

The concept of rehabilitation first appeared around 1880 with the development of hospital-schools to prepare crippled children to function in society (Byrom, 2001). Adherents of this approach viewed disability as a deficiency that could be overcome with assistance from professionals whose role was to treat the social and medical problems these children faced (Burch & Sutherland, 2006). The rehabilitation approach was expanded to address the increasing number of disabled veterans after World War I (Strauss, 1965).

Stiker (1999) pointed out that “the notion of ‘rehabilitation’ [implied] returning to a point, to a *prior* situation” (p. 122), suggesting that disability was a deviation from the norm of nondisabled existence and that the goal of rehabilitation was returning the disabled individual to this state. During the early 20th century, the focus shifted from its original emphasis on social rehabilitation, providing education and training so that disabled individuals could find a place to fit in society, to medical rehabilitation, which consisted of surgical and technological intervention to correct the impairments of disabled persons (Byrom, 2001).

In the functional limitations (or rehabilitation) model, the main argument is that disabilities cause limitations in a person’s ability to perform specific functions of daily life (Bryan, 2002). Like the medical model, the functional limitations model of disability is exclusively focused on the person; the individual, rather than society, is rehabilitated (Imrie, 1997). But as Nagi (1965) explained, unlike the medical model, which focuses on pathology and cure, the rehabilitation model focuses on functional limitations and disabilities. Functional limitations may include difficulties moving, breathing, working, or caring for oneself independently (Bickenbach, Chatterji, Badley, & Üstün, 1999). The functional limitations model is essentialist in nature; it does not acknowledge that the culture, situation, or environment can influence the extent to which functional limitations affect people’s ability to do things (Imrie, 1997). Adherents of the model also see disability as dichotomous; that is, there are only two kinds of people in the world—those who have functional limitations and those who do not (Drum, 2009). Only those who do not have functional limitations—the able-bodied—can be successful (Imrie, 1997).

The goal of this model is to improve disabled people’s functional capabilities so that they are “restored to their previous condition,” that is, the usual human condition of “ordinariness” (Michalko, 2002, p. 152). Unlike the medical model, the functional limitations model does not address the underlying condition that caused the impairment; rather, the emphasis is on improving the individual’s functional capacity (Drum, 2009). To do so, rehabilitation personnel assess functional limitations and develop rehabilitation plans that focus as much as possible on restoring individuals to their former level of functioning and assisting them in adapting to their environments (Bryan, 2002). As Michalko (2002) pointed out, in today’s society, people tend to be judged by how well they are able to carry out activities, “make a living,” and contribute to society. There appears to be a hierarchy of disability, with physical and occupational functioning being the most important to address in rehabilitation (Imrie, 1997). As such, “the problem of disability ... becomes the problem of

inability” (Michalko, 2002, p. 156). Disability resource office staff working from a functional limitations model would focus on providing accommodations, adaptive equipment, and individual coaching to enable students with disabilities to “overcome” their functional limitations and accomplish their academic goals, succeed in college, and enter the workplace.

There are a number of criticisms of the functional limitations model. From a social justice perspective, the functional limitations model, as with the medical model, places power and control in the hands of medical personnel who determine what tests and treatments should be administered to address the individual’s functional limitations and when the individual’s functional capacity has improved enough to consider the rehabilitation a success (Lutz & Bowers, 2003/2007). The reliance on testing by disability resource staff to verify learning disabilities and allow students to secure accommodations is based on the functional limitations model. In addition, the individual must be a “good patient” and comply with the instructions the rehabilitation professional provides. Disabled persons who cannot successfully regain full function remain dependent on others for care and are left “in a chronic role of dependency” (Lutz & Bowers, 2003/2007, p. 12). They are socialized into accepting the idea that they are “inferior” to those who are not disabled and behave in ways that conform to the stereotypes and behaviors that others expect (Imrie, 1997). In addition, the rehabilitation model does not value individual difference. Individuals with disabilities that make them unique must be rehabilitated so they are similar to everyone else and can assimilate in society (Stiker, 1999).

Others point out that the functional limitations model ignores the effects of aspects of the environment by focusing only on internal bodily limitations (Bickenbach et al., 1999; H. Hahn, 1991). It also fails to consider ways to change the environment to suit disabled persons by expecting the disabled person to adjust to the environment (Bryan, 2002). For instance, vocational rehabilitation services, which many disabled individuals rely on for assistance in attending college or securing employment, assisted Nancy when she determined that she could not negotiate the amount of walking required in her position at Penn State. They provided her with a motorized scooter to use on campus. Rather than recommending that the university adjust her work environment by moving her classes to the building in which her office was located, they considered only ways to adjust her personal mobility.

Medical personnel working from a rehabilitation perspective have also been criticized for focusing so much on the causes of conditions affecting disabled individuals that they tend to segregate them into disease categories and separate them from other people with different disabilities rather than

bringing them together to address common issues, such as discrimination and environmental barriers (Bryan, 2002). In addition, reducing a person to a condition ignores other aspects of the whole person (Bryan, 2002).

Social Model

The social model of disability originated in the United Kingdom and was based on *Fundamental Principles of Disability* (1976), a document written and published by a disability activist group, the Union of the Physically Impaired against Segregation. Academics in the United Kingdom, especially Michael Oliver, Colin Barnes, and Vic Finkelstein, formalized the ideas set out in the document to create the social model of disability, the most often cited version of which was written by Oliver (1990). The social model was developed as an alternative to the medical and functional limitations approaches to which many disability activists objected (Drum, 2009). Many variations of the social model have evolved since the 1980s, including materialist (Finkelstein, 1980), cultural (Barnes, 1991; Shakespeare, 1994), and feminist (C. Thomas, 1999) versions (Tregaskis, 2002). The social model was introduced primarily for use by disability professionals and activists. As a result, Oliver (2004) stressed that it was not a disability theory. Often referred to as the “big idea” of the disability movement in the United Kingdom, the social model had a major influence on building the collective disability consciousness of its members by getting disabled people to think about their commonalities and the barriers they all faced (Oliver, 2004).

Barnes (1991) defined *disability* as “the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others due to physical and social barriers” (p. 2). Thus, disability is a socially constructed concept, its meaning based on the perceptions of those making up society (Llewellyn & Hogan, 2000; Olkin, 2011b). Proponents of the social model argue that disability is located in the social environment, which they view as exclusionary and oppressive, rather than in the body (Marks, 1999). Social modelists define the environment broadly as including physical, economic, and political factors, as well as social dimensions (Tregaskis, 2002). They understand disability as the barriers that individuals with impairments have to address in all aspects of their lives, including work settings, housing options, education opportunities, civil rights, transportation, and access to the architectural environment (C. Thomas, 2004).

Initially impairment was not important to social modelists in that they saw disability as “wholly and exclusively social ... [and] disablement [as having] nothing to do with the body” (Oliver, 1996, pp. 41–42). Later writers modified

this position, defining impairment as “limitation in a person’s physical, mental or sensory functioning [that] ... only become[s] salient and disabling in specific settings” (Marks, 1999, p. 80). Social modelists, however, continue to believe that “*disability* is the overriding priority for ... the disabled people’s movement” (C. Thomas, 2004, p. 24). Disability resource office staff working within the social model would be interested only in environmental barriers such as inaccessible buildings, lack of captioning on videos, or inaccessible technology rather than any factors related to students themselves.

The main goal of adherents of the social model is to make sense of and change “disabling socio-political and cultural practices” (Goodley, 2004, p. 123). Social modelists also argue against segregated, special, or adapted facilities for disabled people since such facilities send a message that disabled individuals are different from other members of the community and cannot fit in the “normal” world (Marks, 1999). Instead, they advocate using universal design (see Chapters 10 and 12) to modify the mainstream environment so that it is accessible to all individuals, with or without disabilities (Marks, 1999).

The strengths of the social model are that it introduced a new way for professional disability workers and researchers to think about disability and raised new research questions amenable to different methodological approaches to better understand the concept of disability (Llewellyn & Hogan, 2000). The social model depathologized disability by focusing on the social environment rather than internal ailments or injuries while addressing what they believed to be the true cause of disability: prejudice and discrimination (Fougeyrollas & Beauregard, 2001). The model also secured some basic changes in society to allow access and inclusion for people with disabilities (Oliver, 2013; Olkin, 2011b).

There are a number of concerns about the social model as well. Critics have focused on the role of impairment and personal stories within the social model, with some arguing that their inclusion would lessen the model’s effectiveness and others suggesting they are critical to a fuller understanding of disability (Shakespeare & Watson, 1997). Abberley (1987) critiqued the minimization of impairment, arguing that like disability, it too was socially produced. Others, particularly feminists, posited that the body should be considered since it has an effect on a person’s experiences (C. Thomas, 2004). Shakespeare (2006a) explained that individuals with degenerative conditions or conditions that cause pain and discomfort would certainly be well aware of the negative aspects of impairments. For instance, Ellen has noted that even when she is working at a camp for children with diabetes, designed to remove all social barriers, she still experiences fluctuations in blood sugar that limit her functioning.

C. Thomas (2004) viewed the type of social barriers addressed in the social model as too limited, in that only material barriers found in the external social world were considered. Marks (1999), as well as C. Thomas (2004), argued that there are also psychoemotional aspects of disability, specifically the effects of social interactions between the “powerless impaired” and the “powerful nonimpaired,” such as families, communities, health services, and educational services, when they make impaired people feel helpless, worthless, unattractive, and so forth. Abberley (1987), as well as Marks (1999) and Vernon (1998), pointed out that the social model ignores individual differences in race, gender, and other social identities, as well as historical time, when considering the effects of the environment on those with disabilities. Finally, Shakespeare (2006a) suggested that the idea that removing all social barriers would erase disability was unrealistic. Anastasiou and Kauffman (2011) explained that removing all barriers for persons with one type of impairment, not a particularly realistic idea itself, could create barriers for persons with another type of impairment. For instance, creating curb cuts for wheelchair users makes following sidewalks with a cane difficult for people who are blind, and allowing emotional support animals into residence halls for students with psychological disabilities presents challenges for students with pet allergies.

Minority Group (Sociopolitical) Model

Also referred to as the sociopolitical model, the minority group model is an expansion of the social model, which proponents in the United States believed used too narrow a view of the environment (Drum, 2009). The minority group model grew out of the disability rights movement in the United States in the 1970s (H. Hahn, 1988; Smart & Smart, 2006). Those associated with this movement distrusted the medical model and medical professionals who controlled all decisions regarding the treatment of disabled persons, leaving disabled individuals with no voice in decisions that affected their lives (Lutz & Bowers, 2003/2007). Disability rights activists also argued that nondisabled academics who had no knowledge of the issues facing people with impairments were often biased and that disabled researchers should take the lead in conducting research about disability since they understood the issues (Longmore, 2003). As a result, disabled academics in the United States, especially Harlan Hahn and Paul Longmore, promoted the new “minority group” approach, which led to its predominance in the 1970s and 1980s as a basis for research and the development of the field of disability studies in the United States (H. Hahn, 1985, 1988; Longmore, 2003).

The goal of this movement was to transfer the “burden of disability” (Lutz & Bowers, 2003/2007, p. 14) from people with impairments to society by creating a sense of community among people with disabilities and strengthening laws to combat discrimination and change public policy (H. Hahn, 1985). Similar to members of other minority groups based on race, gender, or sexual orientation, proponents of the minority group model argued that people with disabilities experience commonalities such as oppression, alienation, and discrimination (H. Hahn, 1991; Longmore, 2003; Scotch, 2000/2009). H. Hahn (1988) argued that nondisabled people oppress disabled people for violating two critical values of Western society in the 20th century: physical attractiveness (in the case of physical disabilities) and individual autonomy. H. Hahn added that “the social stigma of a disability fundamentally derives from the fact that the resulting functional impairments may interfere with important life activities” (p. 43). Disability resource staff working within the context of the minority group model are likely to stress the importance of building awareness among students with disabilities of the oppression and discrimination they face on campus and within society. They would be likely to create consciousness-raising groups and encourage an activist orientation among students for obtaining rights and policies to create a more just environment.

Impairment and disability are considered to be different concepts within the minority group model (Nielsen, 2012). While not explicitly defined in the model, *impairment* is used to refer to a mental or physical disease, injury, or ailment affecting the person’s body or mind; *disability* is defined as “the product of the interaction between individuals and the environment” (H. Hahn, 1991, p. 17). People’s surroundings, rather than their bodies, are the sources of the limitations they face (H. Hahn, 1988), and social context greatly influences how disability is viewed and treated (Nielsen, 2012). H. Hahn (1991) went on to explain that “disability is not a personal defect or deficiency [but rather it is] primarily the product of a disabling environment” (p. 17). As such, it is the environment that must be adjusted to meet the person’s requirements rather than the person adapting to the environment (Bryan, 2002). H. Hahn (1988, 1991) saw societal attitudes as the most powerful environmental factor affecting people with disabilities. He offered three postulates to this proposition: (a) negative attitudes are the major cause of the barriers that people with disabilities face, (b) public policy drives all aspects of the environment, and (c) social attitudes are influential in the creation of public policy.

The minority group model is particularly important in the history of disability since it was instrumental in the passage and enactment of disability rights laws and the development of disability activism in the United States

(Drum, 2009; Longmore, 2003). It also does a better job than the medical and functional limitations models of explaining the daily experiences of disabled people, since in most cases, prejudice and discrimination have more of an impact on lives than do functional limitations (Scotch, 2000/2009; Smart & Smart, 2006). H. Hahn (1985) also pointed out that the minority group model is more complex than either the medical or social models since it considers the interaction of the person and the environment rather than only one of these factors.

The minority group model nevertheless also has some weaknesses. Batavia and Schriener (2001) viewed it as “over simplified,” suggesting that it leaves out consideration of important factors including individual, family, and cultural variables that influence a person’s ability “to live independently and productively” (p. 692). Lack of attention to the role of the individual’s body is also a point of contention (Drum, 2009; Imrie, 1997), as is the narrow focus on public policy approaches to reduce discrimination toward disability (Imrie, 1997). Many critics have argued that the variability of impairments and the difficulties of coming together as a group act against the development of a minority group consciousness (S. R. Jones, 1996). Perhaps the most salient criticism of the minority group model in the view of social justice educators is its construction as a deficit model that supports the stereotype of individuals with disabilities as being victims in need of support (S. R. Jones, 1996).

Critical Approaches to Disability

Two more recent models have strong potential for shaping the work of disability professionals and scholars: critical disability theory and critical realism. Both fit under the umbrella of critical theory.

Critical Disability Theory

Critical disability theory (CDT) is a framework that emerged from postmodern and postconventional critiques of existing disability theories (Corker, 1998; Corker & Shakespeare, 2002; L. Davis, 2002; Meekosha, 2006; Meekosha & Shuttleworth, 2009; Shildrick, 2009, 2012). Foucault (1977, 1980) championed critical perspectives, yet disability studies theorists did not adopt his ideas until the 1990s (Corker, 1998, 1999; Corker & Shakespeare, 2002) and only very recently has CDT entered the higher education and student affairs literature (Meekosha & Shuttleworth, 2009; Peña, Stapleton, & Schaffer, 2016; Vaccaro, Kimball, Wells, & Ostiguy, 2015).

Although critical of the medical and functional limitation models, CDT arose primarily as a challenge to the perceived hegemony of the social model (L. Davis, 2002). Specifically, Corker (1999) argued that thinking about disability only as a form of social oppression was incomplete, explaining, “In its efforts to produce a collective notion of disability, disability studies has inadvertently reproduced the kind of representations and theoretical structures that it has historically claimed to challenge” (p. 629). CDT scholars questioned metanarratives (L. Davis, 2002), particularly those within the social model that prescribe dichotomies such as individual/society or impairment/disability (Corker & Shakespeare, 2002; Meekosha & Shuttleworth, 2009; Shildrick, 2012). Scholars working within a CDT framework also critiqued ideas associated with the minority model, noting that a “conundrum in disability research is the assumption that all participants in a particular study will form part of a collective ‘disabled identity’” (Smith-Chandler & Swart, 2014, p. 424).

As a model, CDT is complex and multifaceted; here we focus on four core components. First, in CDT, *disability* is defined as “slippery, fluid, [and] heterogeneous” (Shildrick, 2009, p. 4). This definition allows disability to change over time and be intersectional; that is, it is shaped by other aspects of social identity, meaning, for example, that a particular form of disability experienced by an Asian American may differ from how that disability is experienced by an African American (Shildrick, 2009). As Smith-Chandler and Swart (2014) stated, “We contend that there is no single, universal, fixed, stable disabled identity and that experiences differ in terms of both individual and contextual factors” (p. 424). A definition of disability that is fluid and temporal can be useful in higher education settings, in that it allows that disability might be recently acquired, or recently diagnosed, or might change in impact over the collegiate experience. Furthermore, it encourages practitioners to take an intersectional approach and understand why some students may not identify as disabled even though they may have an impairment. For instance, rather than assuming a student who refused to accept accommodations for a learning disability was being stubborn and unrealistic about his ability to succeed with the disability, a disability resource professional using a critical disability theory approach might probe to understand why the student felt this way and how learning disabilities were viewed in his family and culture.

Second, CDT includes local knowledge as a method of understanding the lived experiences of people with disabilities (Meekosha & Shuttleworth, 2009). Given the importance of campus climate, locally situated knowledge is imperative for anyone working with disabled people in higher education settings. For example, knowing that snow removal along accessible paths is prioritized by

facilities staff is valuable, and not to be assumed when coming from a campus where these paths either were not prioritized or there was no snowfall.

Third, CDT educators value emancipation and spotlight issues of human rights and social justice (Meekosha & Shuttleworth, 2009). Practitioners may assume that important social justice topics for disabled people primarily relate to employment, education, and physical access. CDT goes beyond the political focus of other theoretical frameworks by bringing social justice into areas that are meaningful for disabled people, such as culture and sex (Meekosha & Shuttleworth, 2009). For instance, individuals with many types of disabilities are frequently and falsely assumed to be asexual; thus, health and education providers should have critical discussions with all clients about healthy sex practices. Those working within a CDT framework encourage campus sex education programmers to include diversity in relation to how people with impaired bodies have sex and foster a disability culture by inviting speakers and promoting disability pride events.

Finally, scholars using a CDT framework posit that both impairment and environment are important and that a relational discourse occurs between embodiment and disability (Meekosha & Shuttleworth, 2009). Unlike other theoretical frameworks that isolate impairment, CDT allows for a “causal relationship between impairment and disability” (Corker, 1999, p. 632). For example, the social model would posit that Kirsten’s spelling impairment is caused by the environment, and practitioners using that model would focus on changing the environment by creating access to spell-checking or other adaptive software. CDT allows a more complex and fluid understanding of a relationship between the inability to spell and the environment. Practitioners employing CDT would recognize that in some environments, the impairment will dominate and environmental alterations, such as spell-checkers or writing on a dry erase board during a meeting, are not useful. Furthermore, by having an embodied component, CDT honors the frustration Kirsten feels when she spells a word so poorly that a spell-checking program cannot even guess what she wants. Hence, using CDT, a professional working in higher education might gain a better understanding of why there are times when impairment matters more, why there are times when environment matters more, and why there are times when the interactions between impairment and society make functional limitations more or less difficult to manage.

CDT offers professionals in higher education settings a unique set of tools to understand disability experiences in a more complex and intersectional manner. Notably, CDT provides a framework that allows faculty, staff, and others in higher education settings to consider identity, intersectionality, campus environments, impairment, and visible and nonvisible representations;

it offers powerful tools to break down hierarchies and include underrepresented voices. Within CDT, students, scholars, and researchers prefer and frequently use disability-first terminology (e.g., “disabled student”), although some also purposefully employ person-first language (e.g., “student with a disability”) in specific situations (Meekosha & Shuttleworth, 2009; Shildrick, 2009). For example, person-first language can be used to show pride or reclaim disability, “move away from the preoccupation with binary understandings” (Meekosha & Shuttleworth, 2009, p. 50), or deconstruct hierarchies of knowledge via discourse analysis (Shildrick, 2009). The use of disability-first language may be uncomfortable, especially in student affairs, which remains a field where the dominant norm emphasizes using person-first language.

Another challenge in using CDT is that fluid or temporal definitions of disability may be challenging to employ within identity-based centers or in developing identity politics. In addition, the tendency of postmodern scholars to use complex and inaccessible language might make CDT inaccessible to individuals without an advanced understanding of philosophical thought (K. Brown, Broido, Stapleton, Evans, & Peña, 2016).

CDT offers unique social justice opportunities but also may pose difficulties for engaging undergraduate students, staff, and community members. Higher education professionals and scholars wishing to integrate CDT in their practice and research should engage with the theoretical lens beyond the limited overview provided in this book. In particular, we direct interested readers to consider Gillies and Dupuis (2013) as an example of how to use CDT to frame a participatory action research study, Meekosha and Shuttleworth (2009) as a resource to better understand social justice implications, and E. V. Peña et al. (2016) as a framework for exploring intersectionality.

Critical Realism

Unlike the other models reviewed in this chapter, critical realism is not a model of disability but a philosophy of science. We include it here because, as applied to the study of disability, it requires that we reintegrate consideration of the physical realities of the body and mind with the constructivist focus on structural and social systems (Shakespeare, 2014). Critical realism arose as an explicit philosophy of science during the 1970s (Bhaskar, 1998) but is grounded in the work of multiple Western philosophers writing across the 20th century (Danermark, Ekström, Jakobsen, & Karlsson, 2002). It was developed to address the limitations of both essentialist perspectives and those of constructivist perspectives in ways that would “serve progressive politics” (Moya, 2000, p. 3).

Applied to disability studies to address shortcomings of the social model (Shakespeare, 2014), critical realism is a paradigm that holds that reality exists in ways that allow us to make causal truth claims. Both physical and social phenomena are thought to exist independent of observers' and participants' perceptions of them. However, understandings of truth and reality are shaped by individuals' identities and experiences such that "the conditions and social relations of the production of knowledge influence its content" (Easton, 2010, p. 120). Thus, "critical realists propose ... there exists a reality 'out there' independent of observers ... [and that] the world is socially constructed but not entirely so" (p. 120).

A second key concept in critical realism is the multilayered nature of reality. Phenomena such as disability have multiple, mutually influencing layers: the molecular, the physiological, the psychological, the social, and the structural/cultural (S. J. Williams, 1999). These layers influence each other, but in nondeterministic ways. Danermark (2002), who has to date made the greatest use of critical realism in writing about disability, gave the example of two people who have a hearing impairment with the same physiological origin. Depending on their linguistic memory, the quality of their sight and light levels in their environment, and their coping skills, they will have varying degrees of functional impairment. Their families and friends will react in multiple ways to their impairment, some in ways facilitative of communication and others in ways less so. The two people may live in different countries, one of which provides extensive support to those with limited hearing and another without such resources. These mechanisms are independent of one another but do influence each other. Understanding hearing impairment requires recognition of the multiple, mutually shaping but independent layers of reality. Disability within a critical realistic perspective, then, is "a relationship between intrinsic factors (impairment, personality, motivation, etc.) and extrinsic factors (environments, support systems, oppression, etc.)" (Shakespeare, 2014, p. 76).

Writers using a critical realism framework (e.g., Shakespeare, 2014) to discuss disability have argued it is important to consider both the body/mind and the social/cultural experience when trying to understand disability and respond to it, as well as to consider the influence of context, knowing that no context-free claims about reality can be sustained (Danermark & Gellerstadt, 2004; Pilgrim, 2014). Shakespeare (2014) made clear that disability cannot be solely understood as a social construction, writing that "even with the removal of barriers and the provision of support, impairment will remain problematic for many disabled people" (p. 85). For instance, a critical realist in student affairs encouraging a student with a chronic disability to become involved on campus would want to ensure that the student took under consideration

not only her specific interests and the accessibility of the organizations she was considering but also factors associated with her physical condition, such as fatigue.

The critical realist approach has two primary limitations. The first is the inaccessibility of the model. Most books and articles about critical realism are written using language inaccessible to those without training in metaphysics and the philosophy of science. The second is that critical realism appears to have made little inroad into the practice of social science. While it is easy to find writing about critical realism, it is more challenging to find research that employs a critical realist approach, especially disability research. Very little writing provides guidance on how to conduct a study from the perspective of critical realism. Articles published in the *Journal for the Theory of Social Behavior*, the primary outlet for critical realist writing, are overwhelmingly theoretical, with very few empirical pieces.

Social Justice (Ableist or Disability Oppression) Model

The social justice (or ableist, or disability oppression) model of disability is based on concepts associated with the overall social justice movement in the United States, which borrowed ideas from the separate civil rights, women's, and New Left movements of the 1960s and 1970s (L. A. Bell, 2013). In this model, concepts such as social justice, liberation, and oppression are used to analyze, evaluate, and transform systems of social behavior, discriminatory institutional structures, and cultural practices (M. Adams, Bell, & Griffin, 2007). The University of Massachusetts Social Justice Education Program has been particularly influential in developing and promoting this model. With the exception of conceptual work introduced by writers associated with the University of Massachusetts program and some research conducted in the United Kingdom, little writing and almost no research in the field of social justice has focused on ableism (Nocella, 2009).

Rather than focusing on *disablism*, which F. K. Campbell (2009) defined as “a set of assumptions (conscious and unconscious) and practices that promote the differential or unequal treatment of people because of actual or presumed disabilities” (p. 4), social justice model adherents “prefer the term *ableism* to define the oppression of people with disabilities” (Griffin, Peters, & Smith, 2007, p. 335). Rauscher and McClintock (1997) explained that throughout history, ableism has functioned to “create an environment that is often hostile to those whose physical, emotional, cognitive, or sensory abilities fall outside the scope of what is currently defined as socially acceptable” (p. 198).

F. K. Campbell (2009) added that ableism equates able-bodiedness with normalcy; by contrast, disability is viewed as abnormal, dependent, and deficient. As such, disabled individuals often cannot fulfill the social and economic roles that society expects, and their talents are not acknowledged (Castañeda et al., 2013; S. R. Smith, 2009). Implicit in the ableist perspective is the belief that disability is a negative status and should be eliminated or rehabilitated if possible (F. K. Campbell, 2009).

Another label for this approach, *disability oppression theory*, is used to describe the dynamics associated with the discrimination and injustice that are directed toward people with disabilities in an ableist society (Castañeda & Peters, 2000). Rather than attempting to “fix” people with disabilities so that they will “fit” into an ableist society, advocates of disability oppression theory promote addressing the oppressive culture so that all individuals are accepted as they are (Castañeda & Peters, 2000; Nocella, 2009). Hutcheon and Wolbring (2012) posited that the concept of ableism is helpful in two ways: it helps to explain the experiences of “ability-diverse” (p. 47) individuals and allows for more effective examination of policy and its effects.

Similar to other forms of oppression, ableism works on cultural, institutional, and individual levels (Castañeda et al., 2013; Griffin et al., 2007; Rauscher & McClintock, 1997). Cultural beliefs, including those regarding beauty, independence, and normality, affect how individuals with disabilities are viewed and treated in society. The policies, practices, and norms established in institutions such as the family, religion, law, housing, health care, and government create barriers for people with disabilities. Individual attitudes such as paternalism, pity, sympathy, disgust, and others expressed toward disabled individuals contribute to feelings of discomfort and distrust that people with disabilities experience in an ableist society (Griffin et al., 2007). The social justice model outlines how people with disabilities overcome these forms of oppression as they move toward empowerment as a result of the establishment of equitable access and accommodation within society and the creation of social structures where all people are able to take on equally important tasks and meaningful roles while connecting with other people interdependently (Castañeda & Peters, 2000).

Three major components unique to the social justice model of disability are its focus on privilege and oppression as major influences in shaping how disability is viewed and experienced in U.S. society; its emphasis on diversity and intersectionality of the disabled individual’s experiences, roles, and identities; and its intentionally educational mission. Social justice advocates point out that throughout time, nondisabled individuals have held the privilege and power to decide how disabled people, as the oppressed group, will be viewed

and treated (Evans, 2008). L. A. Bell (2013) explained that oppression of individuals with disabilities has four qualities. It is *pervasive* in that inequality is “woven throughout social institutions as well as embedded within individual consciousness” (p. 22). It is *restrictive* in that lives of individuals with disabilities are constricted by structural and material barriers. It is *hierarchical* as members of the dominant nondisabled group are advantaged by disempowering the oppressed disabled group. Finally, it is *internalized* by disabled individuals as well as nondisabled dominant group members.

Oppression has three dimensions: context, application, and consciousness (Hardiman, Jackson, & Griffin, 2013). As already noted, oppression in the form of ableism can occur at the individual level, through the attitudes and behaviors of individuals; it can take place in institutional settings, including family, government, education, religion, and the legal system; and it is also located at the social/cultural level when expressed as values, beliefs, and norms. Oppression is applied in these same locations—individually through attitudes and behaviors; institutionally through laws, policies, and practices; and societally through values, beliefs, and customs. Finally, the dimension of consciousness indicates that oppression can be intentional or unintentional. Similarly, social justice educators and advocates can address oppression in each of these contexts and locations. For instance, diversity courses should include units on disability to dispel students’ negative attitudes, misinformation, and stereotypes about people with disabilities; social justice advocates can review policies and practices in areas such as admissions, residence life, and student activities to ensure that they are equitable for all students (see Chapters 14 and 15); and advocates can point out underlying values and beliefs that may appear in campus media, such as newspapers, handbooks, and websites.

The second aspect of the social justice model addressed much more extensively than in other models is diversity and the intersectionality of experiences, roles, and identities. As S. R. Smith (2009) pointed out, in addition to structural injustice, discrimination against disabled individuals is also caused by “identity exclusion” (p. 25), when nondisabled individuals assume what the experience of disabled people is rather than considering the variation in experiences that disabled individuals actually have. Proponents of the social justice model stress the diversity of people with disabilities, including their broad range of physical, emotional, and mental capabilities; their other social identities; and their various personality characteristics, as well as the different social contexts in which they live (Castañeda et al., 2013; Evans, Assadi, & Herriott, 2005).

All of these variables influence people’s worldviews, self-perceptions, and how others perceive and treat them. Taking into consideration individuals’

various social identities, including gender, race, religion, age, sexual orientation, and social class, in relation to their impairments is especially important for understanding the meaning that the individual, other people, and society will attach to their disabilities (Castañeda & Peters, 2004; Griffin et al., 2007). For instance, because the norms of behavior for young African American children are different from those for White children, African American children are much more often diagnosed as having attention deficit disorder than are White children (see Chapter 5 for further discussion of identity). As Hardiman et al. (2013) stated, “Our various social identities interrelate to negate the possibility of a unitary or universal experience of any one manifestation of oppression” (p. 30).

The social justice model is intentionally educational, unlike other models we have addressed. MacKinnon, Broido, and Wilson (2004) listed three important dimensions of social justice advocacy in education. Applied to disability, they are (a) providing support to students with disabilities; (b) educating both students with disabilities and those who are not disabled about the existence of disability oppression, working with them to create an environment that values differences, and teaching them to advocate for their own and others’ liberation; and (c) working to change institutional structures and policies that support oppression of those with disabilities.

Four goals are associated with the social justice model: elimination of ableism, redefinition of normal, respect and equity, and development of a positive disability identity. Eliminating ableism involves changing the physical and social environment so that disabled individuals can function effectively (Griffin et al., 2007). Implementing universal design principles both in and out of the classroom is one strategy for accomplishing this goal at the institutional level (see Chapters 10 and 12). Legislation to eliminate discrimination and environmental barriers is another means that the government has used to address ableism (Rauscher & McClintock, 1997; see Chapter 3 for a discussion of legal aspects of disability.) In recent years, social justice education has been used to raise individual awareness of ableism and promote equity, access, and transformation of societal systems to create just institutions and cultural values of respect and equal treatment for all people (Hackman, 2008).

Redefining normalcy “so that physical, mental, and sensory differences are no longer viewed as abnormal” (Griffin et al., 2007) is another goal of the social justice model. Within the ableist system, certain characteristics of the human mind and body, constructed as “normal,” are privileged; others, associated with disability, are viewed as deficient and inadequate (F. K. Campbell, 2009). Individuals with minds and bodies that are not “normal” are excluded by the

dominant nondisabled group from many aspects of economic and social life (Nocella, 2009). To reintegrate individuals with disabilities into society, the narrow definition of what is considered normal needs to be expanded so that their differences are accepted and valued (Rauscher & McClintock, 1997). Social justice educators stress that concepts such as normalcy, average, standardization, and equality are socially constructed and there is no such thing as an objective “norm” or “average” (Nocella, 2009). Rather, all people are different mentally and physically, leading social justice educators to promote “respect of differences not of equality” (Nocella, 2009, p. 155). An example of a narrow definition of what is normal is the assumption that all people should be able to navigate by walking. A social justice approach would suggest that any form of navigation, including using motorized scooters or wheelchairs, is appropriate. Given this assumption, all entrances to buildings would be wide and have automatic door openers; entrances would be approached using sidewalks that were flat or slightly inclined rather than stairs.

The goal of promoting respect and equity, then, is intertwined with respecting difference. Respect entails self-respect as well as respect from others and for others. As L. A. Bell (2013) stated, “Social justice involves social actors who have a sense of their own agency as well as a sense of social responsibility toward and with others, their society, and the broader world in which we live” (p. 21). This vision of society can best be achieved when “the distribution of resources is equitable and all members are physically and psychologically secure” (L. A. Bell, 2013, p. 21). S. R. Smith (2009) argued for a “productive tension” (p. 27) in the creation of “socially just human relations” (p. 27) that would enable nondisabled individuals to identify with and appreciate disabled individuals by engaging with them and sharing positive experiences but also recognize that people with disabilities have a right to expect structural changes in the social and political environment to enable them to successfully negotiate their surroundings. In the postsecondary setting, advocates of the social justice model of disability stress the right of every person to have a fulfilling and successful academic and cocurricular experience in which each person’s complete identity and specific experiences are taken into account (Evans & Herriott, 2009). Social justice educators also “seek to create awareness on the campus regarding disability as another expression of human diversity similar to race, social class, gender, and sexual orientation” (Evans & Herriott, 2009, p. 36). Diversity classes and programs that include information regarding disability are effective ways of accomplishing this goal.

Similar to the minority group model, the social justice model is invested in achieving a positive identity among disabled people. Understanding that disability is caused by social, economic, and environmental barriers rather than

“conditions” that are psychological or physical in nature allows persons with disabilities to redefine themselves as strong and capable individuals (Rauscher & McClintock, 1997). Within this model, disabled individuals are proud of their differences and work to make others aware of their accomplishments and talents (Rauscher & McClintock, 1997). For example, disabled individuals may develop particular insights as a result of their experiences as “outsiders” that can be of benefit to other people (S. R. Smith, 2009). In the college or university setting, ensuring that students with disabilities are provided with opportunities to engage in cocurricular activities and take on leadership positions enables them to use their skills and talents in positive ways that convey to others that they are capable and encourages development of a positive disability identity.

The social justice model is more complex than earlier models in its understanding of how systems of privilege and oppression affect how individuals with disabilities view themselves and how others view them. It also is much more attentive than other models to the intersectionality of social identities and the unique aspects of each person’s life as a disabled person. However, like other models, it does not account for the role played by impairments in the everyday life of many people with disabilities, particularly those who experience chronic illness and pain on an ongoing basis. To begin to address this concern, we next turn to two promising approaches that consider bodily experiences as well as broader disability communities.

Emerging Models

Disability justice and the interactionist model of disability are two emerging models that offer political and multifaceted approaches to understanding disability. In particular, the interactionist model is useful in that it is based on two studies of disabled college students.

Disability Justice

Disability justice is a new framework for disability advocacy, originally conceptualized in 2005 by a group of queer women of color who are also disabled activists (Berne, 2015). Mingus (as cited in Taormina-Weiss, 2013) argued, “Disability justice is a multi-issue political understanding of disability and ableism, moving away from a rights based equality model and beyond just access, to a framework that centers justice and wholeness for all disabled people and communities” (para. 5).

Disability justice activists looked to create a movement that addressed the shortcomings of the disability rights movement, which they saw as focused on White, economically privileged, heteronormative people and approaches (Berne, 2015). The disability justice movement exists primarily online, created by activists rather than scholars; this origin is congruent with the movement's focus on creating change rather than theorizing.

Mingus (2014) captured a core principle of disability justice, writing:

We recognize that ableism is connected, tied up with and mutually dependent on other systems of oppression and that we cannot end ableism without also ending white supremacy, economic exploitation, colonization, and gender oppression. Disability justice requires that we no longer build single-issue analysis, but instead build frameworks that can hold the complexities of our lives. (p. 110)

Another key idea in disability justice is that of interdependence, a direct challenge to the disability rights argument that people with disabilities want to be independent. Copley (2011) wrote, "Ableism depends on maintaining the myth that we can be self-sufficient if we are strong enough—the myth of independence" (para. 6). In a disability justice perspective, there is recognition of and value in "interdependence, in which other people are necessary for physical, emotional and community health and well-being. Interdependency values our connection to others and communities" (Copley, 2011, para. 6). This emerging model offers new voices and perspectives to understanding disability, particularly as experienced by those with multiple marginalized identities. Disability resource office staff proponents of this model would focus on disabled students as people with many different yet intertwined social identities and stress the importance of working together for change.

Interactionist Model of Disability

Two studies of college students with disabilities served as the basis for an interactionist model of disability developed by Evans and Broido (2011). The first study was a phenomenological exploration of how students with disabilities perceived their involvement in social activities, organizations, and leadership positions, as well as the effects of their experiences on identity development. The second study was a phenomenological exploration of the collegiate experiences of students who had Type 1 diabetes.

Building on Lewin's (1936) interactionist model, Evans and Broido (2011) argued that students' ability to function in an environment is an interaction of the environment, the person, and the person's impairment. Each of these areas

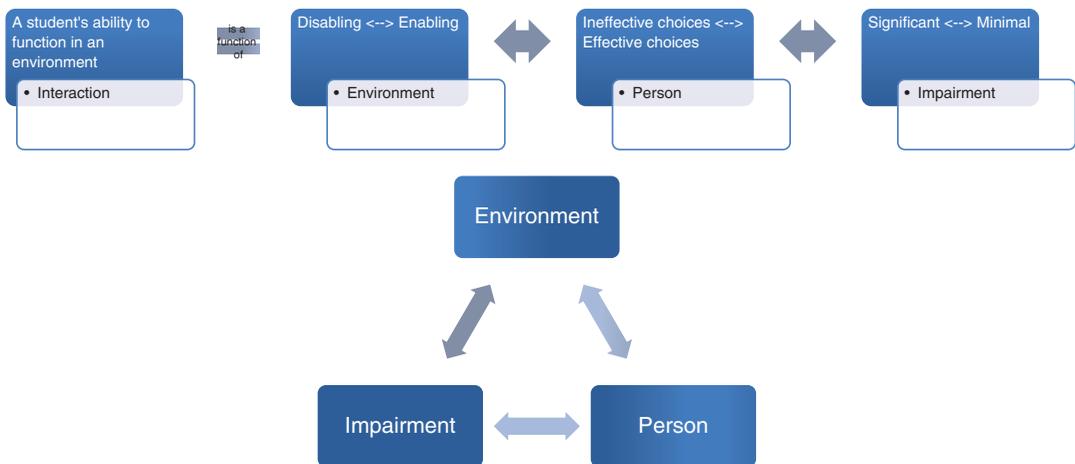
is dynamic: environments can range from enabling to disabling, people can make more and less effective choices, and impairments can vary from minimal to significant. The three elements influence each other as well. Environments can support individuals' ability to make effective choices, and individuals can influence their environments; the extent of impairment can influence people's ability to make effective choices, and the choices they make may (depending on the type of impairment) influence the impact of the impairment. The environment can influence the impact of the impairment and to a small degree; the extent of impairment might influence the environment (see Figure 2.1). A student affairs professional using an interactionist perspective would examine the degree to which specific aspects of the campus environment were disabling, the effectiveness of the individual student's choices, and the type and severity of the student's impairment, as well as how these factors all intersect and contribute to the specific situation the student was experiencing. The student affairs educator could help the student to understand that her experiences are fluid and can be changed by altering one or more of these variables.

Conclusion

Returning to Nancy's story that started this chapter, multiple models of disability shape the experiences of students, faculty, and staff with disabilities. Vestiges of the moral model shape the thinking of many individuals, as Nancy learned. Other older models, such as the medical model and the functional limitations model, continue to guide the work of disability resource offices on many college campuses, as well as vocational rehabilitation services that many students use. Therefore, an understanding of all of the models discussed in this chapter is imperative.

L. A. Bell (2013) posited, "Practice is always shaped by theory, whether formal or informal, tacit or expressed" (p. 22). How individuals approach disability, how they identify problems that need to be addressed, how they choose to address them, and the solutions they determine to be appropriate are all influenced by theory (L. A. Bell, 2013), specifically by the models they choose to frame their understanding. We recommend using concepts drawn from more than one model as each can provide helpful insight that another one may not (Bryan, 2002). We do believe, however, that a social justice approach provides the strongest foundation from which to understand the impact of disability and how to address ableism in society since its principles are well developed and the model is based on inclusiveness and respect for all people. Once this foundation has been established, concepts from the critical

FIGURE 2.1. INTERACTIONIST MODEL OF DISABILITY



Source: Evans and Broido (2011).

and interactionist models, as well as disability justice, can add to the manner in which disability is understood and ableism is addressed, since they are more fluid and include more complex and dynamic understandings of intersectionality. Throughout this book, we ground our thinking in the social justice perspective, while also using ideas and concepts from various models and theories to explore the wide range of issues that must be addressed when working with disabled students in higher education settings.

Discussion Questions

1. Which models of disability most closely align with or inform current practices on your campus?
2. How might using one of the emerging models of disability inform policies and practices on campus differently than the established models?
3. How do you see the various models of disability being informed by and informing societal expectations of disability?

Appendix: Summary of Disability Models

	Definition of Disability	Main Ideas	Practitioners	Further Reading
Moral	Disability is a defect. It is also defined as “bad”; as a result, individuals with physical and mental impairments must have done something “wrong” that contributed to their condition.	Disability is caused by a moral lapse, sin, or the will of a higher power (e.g., God). People with disabilities bring their impairments and associated suffering on themselves because of their negative actions. If a higher power has caused this, “it is God’s will.”	Practitioners should know that specific religious beliefs viewed disability as God’s punishment or “the work of the devil” (Drum, 2009, p. 27) and know that people with disabilities historically were shunned, used as entertainment, or viewed as weak. They should understand how vestiges of these ideas are present today in the literature, pop culture, and stereotypes.	Drum (2009); Olkin (1999)

(continued)

	Definition of Disability	Main Ideas	Practitioners	Further Reading
Medical	Disability is a product of biology in which a congenital or chronic illness, injury, or some other departure from “normal” biomedical structure or functioning has consequences for an individual’s activities of daily living and, ultimately, for the individual’s ability to participate in society” (Scotch, 2000/2009, p. 602).	<p>Rooted in the scientific method, the problem resides in the individual, who must learn to cope with the impairment.</p> <p>Individuals are placed in stigmatizing categories (e.g., the blind, the learning disabled). Categorization of disability is dependent on medical diagnosis and classification systems. Disabled people are compared to an idealized notion of normality. The focus is on pathology and cure. Decisions are made by medical professionals. Family or professionals are responsible for those who cannot be cured.</p>	Practitioners should be aware that the medical model is traditionally the dominant one. The focus on objectivity and scientific method associated with the model suggests and reinforces ideas of authority. The medical model is not particularly helpful for practitioners as it locates the problem within the individual rather than considering other factors such as the environment, prejudice, and discrimination. It also implies that “something is wrong” with the person rather than honoring natural human variation.	Altman (2001); Masala & Petretto (2008); Scotch (2000/2009)

Functional limitations	Disability is a deficiency that can be overcome with assistance from professionals whose role is to treat the functional limitations.	Disabilities cause limitations in a person's ability to perform specific functions of daily life. Disability is located in the individual, and the focus is on functional limitations (e.g., difficulty hearing). The goal of this model is to improve or restore capabilities so the person is as "normal" as possible. Unlike the medical model, this limitations model does not address the underlying condition that caused the impairment.	Practitioners should know that the functional limitations model places power in the hands of medical authority rather than the individual. This model also contains language that disability resource providers commonly use when assessing appropriate accommodations. The model ignores critical factors such as the environment and the causes of conditions, and it does not value individual differences.	Bryan (2002); Imrie (1997); Michalko (2002)
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	Definition of Disability	Main Ideas	Practitioners	Further Reading
Social	Disability is “the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others due to physical and social barriers” (Barnes, 1991, p. 2).	Disability is a social construct. Environmental barriers isolate and exclude people with disabilities from full participation in society. Limitation of activity is caused by social organization rather than impairment. The experience of disabled people is dependent on social context and differs in different cultures and at different times. Goals are barrier removal, including both environmental and attitudinal barriers; making imbalance of power visible; and shifting the burden of disability from disabled people to society.	Practitioners should be aware that the social model depathologizes disability. This model frequently has support from disability activists and can be used to place focus on the campus environment, not the individual. This model is effective when discussing and trying to change physical, attitudinal, and social barriers to access. However, the model does not account for individuals’ lived or bodily experiences (e.g., pain).	Barnes (1991); Finkelstein (1980); Oliver (1990); Oliver & Barnes (2012); Shakespeare (2006); Tregaskis (2002)

Minority group	Disability is “the product of the interaction between individuals and the environment” (H. Hahn, 1991, p. 17). People with disabilities are seen as a minority group oppressed by a nondisabled majority group for violating the norms and values of nondisabled society: physical attractiveness and individual autonomy.	Prejudice and discrimination are causes of problems for people with disabilities. Postulates: (1) “Aversive attitudes are the basic source of the barriers encountered by persons with disabilities”; (2) “All aspects of the environment are shaped or molded by public policy”; (3) “Public policy is a reflection of widespread social attitudes” (H. Hahn, 1991, p. 17). The model focuses on commonalities of people with disabilities. Goals are building a sense of community among people with disabilities and strengthening laws to combat discrimination and change public policy.	Practitioners can use this model to specifically target issues of prejudice and discrimination and expand beyond environmental barriers. This model was successful in obtaining disability rights laws and encouraging activism. The variability of disabling conditions can act against minority group consciousness. Shakespeare (2014) argued that it is not appropriate to assume ideas should transfer from one type of oppression (e.g., race) to another (e.g., disability). The minority model does not challenge deficit-based stereotypes.	L. J. Davis (1995); H. Hahn (1985, 1988, 1991); Longmore (2003)
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	Definition of Disability	Main Ideas	Practitioners	Further Reading
Critical disability theory (CDT)	Disability is fluid and can be changed over time. Critical disability theorists choose not to define disability, as many are operating in a postconventional paradigm that inherently questions boundaries and definitions.	Posits that thinking about disability only as a form of social oppression is incomplete and questions metaphors and narratives, particularly those associated with the social and medical models. In particular, CDT allows for the critique of prescribed dichotomies such as impairment/disability or individual/society. Themes include local knowledge, emancipation and human rights, and the relationship between embodiment and disability.	This model encourages practitioners to consider how disability interacts with other aspects of social identity and recognize that the experience of disability shifts over time. Most writing about CDT is intended for academic audiences with existing knowledge of postmodern theory; other readers likely will find the writing style challenging.	Corker (1998, 1999); Corker & Shakespeare (2002); Meekosha & Shuttleworth (2009); E. V. Peña, Stapleton, & Schaffer (2016); Shildrick (2012)

Critical realism (CR)	Disability is “the outcome of the interaction between individual and contextual factors, which includes impairment, personality, individual attitudes, environment, policy, and culture” (Shakespeare, 2014, p. 77).	Draws on the ideas of Kant, Marx, and other Western philosophers. Postulates: (a) An independent reality exists, and the world is partly socially constructed. (b) Reality is multilayered in nature. (c) Disability is a relationship between extrinsic and intrinsic factors.	Encourages practitioners to consider multiple aspects of disability, including the physical body, individuals’ reactions to their own disability, and social considerations, including others’ reactions, policies, and cultural norms. Writing about CR is highly academic and grounded in philosophy, which may be unfamiliar to many practitioners.	Bhaskar (1998); Danermark (2002); Danermark, Ekström, Jakobsen, & Karlsson (2002); Shakespeare (2014)
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	Definition of Disability	Main Ideas	Practitioners	Further Reading
Social justice	The concept of ableism is central to social justice. Implicit in the ableist perspective is the belief that disability is a negative status. However, rather than attempting to “fix” people with disabilities so that they will “fit” into an ableist society, advocates address the oppressive culture.	Employs concepts such as social justice, liberation, and oppression to analyze, evaluate, and transform systems of social behavior, discriminatory institutional structures, and cultural practices (M. Adams, Bell, & Griffin, 2007). The focus is on ableism—the oppression of people with disabilities. Postulates: (a) Focus on privilege and oppression. (b) Emphasis on diversity and intersectionality of experiences, roles, and identities. (c) Goal of educating both individuals with disabilities and those who are not disabled about the existence of disability oppression.	Practitioners can use the concept of ableism to analyze and assess their campus environment and departmental policies. Rather than locating the problem within the individual with a disability, practitioners can use the social justice model to change oppressive components of the broader culture, including ideas (e.g., beauty, independence, normality), policies (e.g., laws), and attitudes (e.g., paternalism, pity, sympathy).	M. Adams, Bell, & Griffin (2007); Castañeda & Peters (2000); Evans (2008); Griffin, Peters, & Smith (2007); Ostiguy, Peters, & Shlasko (2016)

Disability justice	Disability is a political experience of oppression, understandable only in interaction with experiences of other social identities (e.g., socioeconomic status, race, gender, sexual orientation).	Disability justice advocates argue that disability is a political experience of oppression that can be understood only in the context of multi-issue commitment to social justice. They argue that access is a baseline, but the goal is transforming society to function for all people and value interdependence.	Disability must be addressed alongside other forms of oppression on campus, including racism, sexism, and other efforts to create more inclusive campuses. All members of the campus should recognize, value, and support interdependent, rather than independent, relationships. Accessibility should be considered a minimal standard, and what is being made accessible must function for all community members.	Berne (2015); Mingus (2014)
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	Definition of Disability	Main Ideas	Practitioners	Further Reading
Inter- actionist	The experience of disability is a consequence of the interaction of three components: the environment, the person, and the person's impairment. Each component itself varies between more or less enabling, and the components influence each other.	Environments vary in how enabling they are; people's choices range from more to less effective, and people's impairments vary from minimal to significant. Components interact with each other; for example, one environment (fluorescent lighting) can heighten migraines, while the same environment with few audible distractions can be more functional for some people with attention deficit hyperactivity disorder.	Practitioners should be aware that how people experience their disability varies, even within a given day. Interventions should help address environmental barriers, personal decisions, and management of impairment, where possible.	Evans & Broido (2011); Broido (2006)