Models of Disability

Models help us think about complex phenomena and make sense of the world. They are best used as perspectives or lenses, not singular and ultimate truths. Each model accentuates certain aspects of disability and allows deeper probing and more nuanced understandings (Altman, 2001). After applying a social, medical, or economic lens, insights need to be consolidated with a holistic understanding formed from multiple perspectives. Relying solely on any one model distorts reality and reduces a complex combination of medical, social, and economic considerations into oversimplifications. Let's consider the insights and pitfalls of the medical and social models.

Medical advancements have improved quality of life for many disabled people, ranging from drugs, to mobility aids, to appropriate rehabilitation. Many people depend on these advancements. Medical approaches become problematic when they attribute all societal exclusion of disabled people to their 'pathologies' and consider the individual to be the root of the problem. They then turn the individual into a site for corrective intervention, ignoring societal ableism which consciously excludes people. An over-zealous pursuit of 'normal' functionality can also push invasive interventions which may not be necessary or desired. The validity and effectiveness of doing things differently is often overlooked (Hansen & Philo, 2007).

The medical model is very closely related to the professional model, which articulates how power and authority over decisions that affect disabled people's daily lives are disproportionately held by professionals who are considered sole 'experts' on disability. Lived experience and related knowledge gets devalued and overruled in favor of professional 'expertise.' Disabled people are then denied agency over their own living situations including whatever support, care, or treatment they may be receiving.

The social model emerged as a progressive response to medicalization. Medicalization frames social problems as medical. It excelled at critically examining social assumptions, attitudes, and structures as forces which actively exclude disabled people. This model ensures that policies, practices, public spaces, public services, and other features of society are held responsible for the exclusions they create. It demonstrates the need to be intentionally accessible. Disabled people could organize and resist policies and practices that framed them as 'the problem.' These same policies and practices place responsibility on disabled and neurodivergent people and people with chronic health conditions to conform to able-bodied and neurotypical society. Although this was a critical shift, extreme applications of the social model effectively removed individual realities of body and mind from disability entirely. Disability and exclusion are exacerbated by inaccessible environments and ableist attitudes, but saying disability is entirely contextual ignores the lived realities of body and mind, such as pain, fatigue, internal experience, and complex identity.

Disability is a nexus of body, mind, and society. No single aspect captures the entire experience of disability. Depending on the challenges we are trying to solve, different aspects of disability, neurodivergence, and chronic health conditions need to be

magnified. This should not divorce these aspects from others, but provide pointed insight into a personal, social, and structural situation that has many layers.

*This work reflects our current knowledge and will be updated as needed. We also welcome your feedback at Equity@umanitoba.ca

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