

Characterizing Traditional and Nontraditional Models of Disability

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Abstract:

Practitioners and scholars dealing with disabilities should have models of disability, in order to have clear perspective on disability and to create better practice and research. As the person's perspective differentiates his/her view on disabilities, it is significant to characterize models of disability. This paper introduces traditional and nontraditional models of disability with a characterization framework. The oldest model of disability is based on religious thought and it remains in the society; it is called the "religious model". The medical model has been dominated among medical practitioners. Aside from that, the social model has been created as an antithesis against the medical model. The problem is that the medical model lacks attention to social phenomenon and the social model lacks attention to medical deficit, so the "hybrid" nontraditional models have been created. These nontraditional models have been developed in several different disciplines, including social work, special education, economics, and rehabilitation. This paper attempts to characterize those models. Additionally, this paper proposes the application of less popular area of theoretical research on disability: Autism Spectrum and analyzing discourse on disabilities.

Key words and phrases: models of disability, medical model, social model, nontraditional models, characterization framework

1. Introduction

Either for practice and for research on disability, the practitioners and/or scholars need perspective for observing and analyzing disability. Disability is seen differently from different perspectives. The models help them for their practice and analysis. One problem is that several different "models" are created, coined, and presented. This paper aims to characterize those models with a literature review; this will help readers choose appropriate models for their own purpose.

2. The Models of Disability: Significance and Framework

2.1. Significance

It is still possible for practitioners and researchers to analyze disabilities with their experimental knowledge. The knowledge lacks, however, a clear perspective for evaluation. The models of disability provide us the measurement instrument. As we look at a mountain, the

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mountain looks differently from different location. Similarly, different perspective offers us to see the different shape of the mountain. This nature differentiates action toward persons with disabilities. Some models claim that disability is solely caused by medical deficit. Some models claim that disability is caused by social system. Some models claim that disability is caused by interaction of both. Thus, it is extremely important to characterize the models of disability and to understand those differences and similarities. This paper offers some examples of analysis on models based on literature review.

2.2. Framework for Characterizing Models

Several models stress the nature of the support which a disabled person can be given. One way of comparing variant models of disability, suggested by Buntix and Shalock (2010), is in terms of these characteristics:

- (1) A clinical assessment, such as an International Classification of Functioning, Disability and Health (ICF) diagnosis, introduced by World Health Organization (WHO);
- (2) The persons with disabilities' selfness on his/her quality of life and revelation (merged with the suggestion by Shakespeare, 2013);
- (3) The need for and the availability of supports.

We might also consider the importance of a characteristic described by Miyazaki and DeChicchis (2012):

- (4) Attention to interpersonal relationships.

We might also consider the importance of a characteristic described by Shakespeare (2013):

- (5) Social oppression.

We might also consider the importance of a characteristic described by Liachowitz (1988):

- (6) Relation between individual, the disability, and the functions of the individual.

We might also consider the importance of a characteristic described by Smart (2009):

- (7) Legislative attention.

Applying the aforementioned points, the following models will be characterized.

3. Traditional Models of Disability

3.1. Religious Model

Smart (2009: 4) states that "Only Moral/Religious Model has a longer history than the Biomedical Model". In terms of this, upon reviewing the models of disability, it should be stressed that it would be difficult for many scholars to define the religious model per se. The tentative definition, however, could be the model that conceptualizes the disability accordingly to religious thought. Clapton and Fitzgerald (n.d.) suggests a Judio-Christian perspective on disability as follows:

These embodied states were seen as the result of evil spirits, the devil, witchcraft or God's displeasure. Alternatively, such people were also signified as reflecting the “suffering Christ”, and were often perceived to be of angelic or beyond-human status to be a blessing for others. (Clapton and Fitzgerald, n.d., para. 6)

However, Miles (2002) argues that “Christian theologians have long pondered the meanings of disability without reaching definite answers”. (Miles, 2002: 121)

Miles (2002) reviews perspectives on disabilities from several religions: Judaism, Christianity, Islam, Hinduism, and Buddhism. Quoting the words of a Muslim with disability, Miles suggests that Islamic thought gives people with disabilities a chance for challenge to himself/herself. Aside from that, Miles (2002) mentions the conflict between Western and Buddhist culture as “The cherished Western notion of the autonomous individual self is challenged by those parts of Buddhist thinking that stress the interdependence and interexistence of all.” (Miles, 2002: 122) In addition, Hinduism has a tradition of recommendation of charity. The most important point of Miles’s discussion, however, is that “Religion, culture, socialization, the communal life of your neighbourhood, were all closely interwoven.” (Miles, 2002: 126) This means that, although a “religious model” could be designed per se by scholars, the model could not interpret disability solely in terms of religious thought. It could be characterized with (2) and (3). In addition, it is important that the religious thought for disability has justified the charitable attitude to persons with disabilities, as many hospitals and social service institutions have been established by religious groups.

3.2. Medical Model

Medical practitioners and several scholars have applied the Medical Model for analyzing disabilities and practice toward the persons with disabilities. Those discussions are quite interdisciplinary; practitioners and scholars within several different fields have written about the model. Llewellyn and Hogan (2000) state that “The medical model views all disability as the result of some physiological impairment due to damage or to a disease process” (Llewellyn and Hogan, 2000: 158). Llewellyn and Hogan’s idea incorporates (1), but they are also interested in (3), as they state: “It should be borne in mind that the evaluation of the person’s present level of functioning might also play a role in shaping his or her future and thereby influence the course of later development”. (Llewellyn and Hogan, 2000: 159) .According to Bricourt *et al* (2004), the medical model incorporates (1), (2), (3), and (6). With perspective of economics, Mitra (2006) mentions the Medical Model. The Medical Model incorporates (3).

There is a similar term: “biomedical model”. Reindal (2008) applies this term. Here it should be stressed that some reservation on criticizing biomedical model: the model exclusively focuses on individual factor of the person with disability. Smart (2009) also uses a similar term, “The biomedical model”, and it incorporates (1) and (3).

Although different models are introduced by several scholars, the two main opposing models are the medical model and the social model. “The medical model of disability is one rooted in an undue emphasis on clinical diagnosis, the very nature of which is destined to lead to a partial and inhibiting view of the disabled individual”. (Brisenden, 1998: 20).

In the context of discourse analysis, which will be mentioned in the section 4.3., the medical model, mentioned by Grue (2011), incorporates (1) and (3).

Considering the above analysis of literature, the medical model or a similar model mostly incorporates (1) and (3), clinical assessment and need for supports. The characteristic (3) could have some social aspects, but that could connote that this characteristic requires a medical perspective.

4. Social Model and Nontraditional Models of Disability

4.1. Discussing Nontraditional Models

Earlier research has identified problems with the “medical model” of disability. However, the distinction between a medical model and an alternative nonmedical model is not black and white. Rather, there are several alternatives to the traditional medical model. Some alternatives stress the importance of the disabled person's quality of life. Here several scholarly literatures will be discussed accordingly to the authors.

Using the characteristics mentioned in section 2.2., we can easily compare the four models described by Ziebland *et al.* (1993). Their “functional model” is characterized solely by (1) its reliance on clinical assessment. Their “subjective distress model” incorporates (2) the self-assessment of the disabled person. Their “comparative” model also relies on (1) a clinical assessment, in this case the older ICIDH (the International Classification of Impairments, Disabilities and Handicaps) diagnostic system. Their “dependence model” incorporates the measurement of the severity of disability using the ADL scale, which is (1) a clinical assessment; however, this “dependence model” is using the clinical assessment to determine (3) the need for supports.

In the context of social work, Llewellyn and Hogan (2000) describe four models: medical model, social model, systems theory, and transactional model. The two earlier models have their basis on physical disabilities and the two latter ones have their basis on psychological theories. In addition these of the medical model, the social model incorporates (5). However, both Shakespeare (2013) and Llewellyn and Hogan (2000) hereby mention that the social model lacks attention to the actual medical deficit of disabled people. The systems theory is hereby defined as “a systems approach to the study of children with physical disabilities involves examining the dynamics that can drive and accelerate the course of development by examining the synergistic influence of the characteristics of the person, and of the environment that produces the behavior.” (Llewellyn and Hogan, 2000: 160). This model cooperates (1), (2), and (3), as that model keeps its attention to the psychological thinking. In addition, this model applies the ecological

perspective. The last one, the transactional model, incorporates (2), (3), and (4). This model focuses on emotional attitude to the environment. In sum, Llewellyn and Hogan's analysis do not deny medical and psychological thinking, even on discussing the social model that is sometimes argued for denying medical thought.

Also in the context of social work, Bricourt *et al* (2004) examines four models: the medical model, the social model, the transactional model, and the systems model. The social model incorporates (5) and (7). This model is mentioned as a sort of synonym of the "minority model". The transactional model incorporates (2), (3), and (6). With the ecological approach, the systems model incorporates (1), (2), (3), (5), (6), and (7), as they mention this model as "putting it all together" on their paper's chapter title (Bricourt *et al*, 2004: 53). Bricourt *et al* (2004) mentions Llewellyn and Hogan (2000) as their use of systems analysis.

In the context of Norwegian special education, Reindal (2008) evaluates four models: the social creationist model, the social constructionist model, the interactionist model, and the biomedical model. Recognizing criticism of special needs education, such as professionals' disagreement and failing integration (Reindal, 2008: 135), Reindal's perspective on disability models is a classification of models with materialist and idealist thoughts. We cannot evaluate the characteristics of each model in Reindal's paper, because she does not provide us the details of each model in her English paper, which is in her Norwegian paper (cf. Reindal, 2007); but I lack sufficient proficiency to her Norwegian paper. Importantly, Reindal urges: "All the four models acknowledge that there is some initial biomedical condition that causes reduced function by the individual." (Reindal, 2008: 139) In other words, we cannot ignore medical factors when discussing, applying, and practicing even "social model" or closer ones, if the practitioners and scholars accept Reindal's argument.

In the context of American special education and with a philosophy of education perspective, Danforth (2001) evaluates three models: the functional limitation model, the minority model, and the social constructionist model. The functional limitation model incorporates (1), (3), and (7). The minority model incorporates (5), (6), and (7). These two models have different perspectives on the characteristic (7). The former focuses on administrative function of the law on disability policy, and the latter focuses on civil rights. The social construction model incorporates (5).

Batavia and Schriener (2001) examines civil rights model or minority group model and independent living model, related with the discussion of *Americans with Disabilities Act* (ADA). The civil rights model or minority group model incorporates (5) and (7). The independent living model incorporates (3) and (6). "However, both the civil rights and independent living models are also unduly oversimplified and do not adequately consider other substantial factors such as individual, family, and cultural variables, which are important in predicting the ability to live independently and productively" (Batavia & Beaulaurier, 2001, as cited in Batavia and Schriener, 2001: 692).

In the context of the self-advocacy of people with learning difficulties (i.e. intellectual disabilities or developmental disabilities) in the United Kingdom, Goodley (1997) examines the individual model and the social model. The individual model incorporates (1), (2), and (3). The social model incorporates (2) and (5). Importantly, both models have attention to (2). However they have slightly different focus; the former focuses on applying “self-determination” for seeking support needs, although “Self-determination of people with learning difficulties is a concept that lies uneasily within the dominant model of disability.” (Goodley, 1997: 369) Besides, the latter focuses on empowerment and its nuances are more political.

With the perspective of economics, Mitra (2006) examines four models: the medical model, the social model, the Nagi model, and the International Classification of Functioning (ICF). The social model incorporates (2) and (5), the Nagi model incorporates (3) and (6). The Nagi model, which Mitra (2006) names, is based on Nagi’s (1965) functional limitation paradigm. It is important to stress that the Nagi model’s focus is the limitation of persons with disabilities. Still, Nagi (1965: 102) also argues that “It should be noted that the degree of limitation is not dependent only on the type of impairment but also on the nature and requirements on these roles and activities.” His argument connotes the existence of interactionist perspective for observing disability. The International Classification of Functioning (ICF) means International Classification of Functioning, Disability and Health that is invented by World Health Organization (WHO). This incorporates (1) and (6). Mitra’s (2006) analysis applies Amartya Sen’s the Capability Approach (cf. Sen, 2002). Applying Sen’s theory, disability is classified into *potential disability* and *actual disability* (Mitra, 2006: 242). More importantly, “the ICF does not cover circumstances that are not health related (Bickenbach, Chatterji, Badley, & Üstün, 1999), such as socioeconomic factors.” (Mitra, 2006: 242). This implies that WHO’s classification does not consider any sociopolitical factor.

Swain and French (2000) propose an affirmation model that was sophisticated in the context of the disability arts movement. The affirmation model is contrasted with the personal tragedy model, which represents the disability as the figure of pity. In the affirmative model “The affirmation of positive identity is necessarily collective as well as individual.” (Swain and French, 2000: 577). Moreover, being contrasted with the social model, in the opinion of Swain and French (2000), the social model is oriented in the societal system and the affirmative model emphasizes the individual experience. The affirmative model incorporates (2), (3), (5), and (7). In particular about this model, the characteristic (7) focuses on policy implication rather than legislation.

Harn (1988) is one of the first scholars to propose the Minority-Group model. She expressed the thought on attitude towards persons with disabilities. Harn (1988: 43) opposes functional-limitations model, which focuses on medical deficits of persons, as “empirical studies based on functional-limitations model of disability have not identified existential anxiety as a

single component of attitudes toward disabled persons”. The minority-group model incorporates (2), (5), (6), and (7).

The social model of disability is emerged from the disability activism in the United Kingdom (UPIAS, 1975) and claims they the cause of disability origins from the social system. Slightly differently, the United States sees the disability as caused by interaction of individual and culture, presumably due to the civil-rights activism, including African-American and Feminism in the country (Sugino, 2007).

Other models are claimed in the history of rehabilitation research. Smart (2009) suggests three models: the biomedical model, the functional model, and the sociopolitical model. The functional model incorporates (3), (6), and (7). The Sociopolitical model incorporates (2), (3), (5) and (7). In particular, originality of the sociopolitical model is that policymakers and practitioners are included in the group of stakeholders for a particular problem. Moreover, in the context of the sociopolitical model, legislation aims at the protection of the rights of clients (Smart, 2009). For foreseeing the possibility of further development of models of disabilities, the later sections briefly discuss two fields, which models of disabilities have rarely dealt with.

4.2. Application of Models: Autism Spectrum

Several types of disability have been discussed outside these models. For instance, Autism spectrum has been rarely discussed in disability models in the social sciences and humanities. Metaphors such as "World Wide Web" (Blame, 2004), and “epitome” (Fromm, 1973) are critically analyzed as the result of medical epistemology toward the concept of Autism (Waltz, 2008). Broderick and Ne'eman (2008) criticize the medical-model and parent/professional oriented discourse on Autism metaphor as follows:

Metaphors of space, of geographic separateness, are common throughout many of the titles cited above, and have been common metaphors drawn upon for decades in autism discourse. Two common variations on this metaphor of there being a cultural/ geographic space that is somehow traversed in autism are the notions of (1) the autistic person¹ arriving from a foreign space? the metaphor of the ‘alien’, and (2) the autistic person retreating or withdrawing behind a ‘wall’ or into a ‘shell’ (Broderick and Ne’eman, 2008: 463)

Autism and developmental disorders are the subjects that are rarely discussed with the social model. Probably because the social model has emerged from the activities for rights of persons with physical handicap (UPIAS, 1975), the social model has nearly ignored the Autism and developmental disorders. My literature search did not find any literature regarding the correlation of the social model and Autism. Several debates, however, are ongoing on the social construction of Autism and developmental disorders. On Asperger’s Syndrome (AS), reviewing

medical literature, Molloy and Vasil (2002) argue that “academic scholarship and, consequently, educational practice in the area of AS, and more broadly special education, must go beyond a deficit perspective, and incorporate and legitimize the experiences and understandings of the children that we are labelling.” (Molloy and Vasil, 2002: 668).

4.3. Application of Models: Analyzing Discourse

Discourse provides practitioners the further understanding for persons with disabilities, which is significantly useful for planning intervention (Igarashi, 2008). The term “Discourse” is used slightly differently with linguistic view and with sociological one, but it is clearly important aspect to understand and develop the practice.

In the context of Critical Discourse Analysis (CDA), Grue (2011) classified four exclusive models of disability. Critical Discourse Analysis is a movement for linguistic social research on the text (e.g. Fairclough, 1995). Grue’s models are the social model, the minority model, the gap model, and the medical model. The social model incorporates (5). The minority model incorporates (7). The gap model incorporates (3) and (7). The focuses of (7) are different between that of the minority model and that of the gap model; the former focuses on the civil rights and the latter focuses on the administrative function of law.

In particular, here I mention some points and critique of Grue’s analysis on the models of disability. First, Grue criticizes the social model as a fruit of Marxist Sociology. One of his critiques is that “A frequently raised criticism of the model is that it has been constructed around an ‘ideal’ disabled person – a male wheelchair user belonging to a dominant ethnic group, who suffers no significant health problems because of his impairment.” (Grue, 2011: 538). In fact, several scholars including Chris Bell, a “Black” (African-American) scholar and activist in Disability Studies, criticized the racist idea behind the social model (Bell, 2010). Grue’s analysis should be examined carefully, but at least we should note that the disability model could be ideologically biased. Second, the minority model regards disability as a cultural group that should be embraced in a multicultural society. Third, the gap model is a majority model in Scandinavian countries. This critique is important in a Japanese context, as Japanese scholarship and bureaucracy admire Scandinavian policies as good practices of social policy in “The Welfare State”, regardless of critiques of Scandinavian innate eugenic ideas (e.g. Ichinokawa, 1999). In addition, for a scholar who employs thesis focusing on discourse on the emergence of *Hattatsu Shogai* [developmental disorders] as a *Seisaku Taisho* [Target of policy] (Kosaka, 2009), Grue’s argument on the gap model is suggestive: “It is also an entry point into the fourth and most problematic model.” (Grue, 2011: 540). Fourth, the medical model, as Brisenden (1998) argues, focuses on the medical deficit of the individual.

5. Discussion

Debate on models of disability often focuses on the nature of *dichotomy between the two*, between the medical model and the social model, but it is actually not simple. Sometimes, the social model has been criticized for its lack of medical attention and the medical model has been criticized of its lack of social attention. The *hybrid* models have been invented by several scholars and practitioners in several different field, including rehabilitation, social work, special education, and economics. These movements connote that medical deficit and social system are non-exclusive elements.

In this paper seven characteristics of models of disability have been mentioned. The significance of emphasizing these models is the balancing between the responsibility of persons with disabilities and the society. As stated above, the social model is triggered by the resistance against oppression for persons with disabilities (cf. UPIAS, 1975). Aside from that, as the claim for medical diagnosis may be the basis of disability identity, the medical model could *not* be totally rejected. Consequently, the significance of the balancing is claimed.

There is a difficulty in balancing regarding analyzing the well-being of persons with disabilities. For instance, imagine that there is a student with deficit on his leg, who is not able to go upstairs in the school building. The medical model could argue that the student cannot go upstairs because he is injured. The social model could argue that the student cannot go to upstairs because the school building does not have an elevator. Is the reality of his situation a simple matter like those arguments? Such a question should be answered with “No.” If the student could rehabilitate himself well with learning how to use a stick, he could walk up the stairs. Here is the importance of application of medical diagnosis and therapy. If the building should get an elevator, who will pay for the installation? Here the significance of budget analysis could be claimed. What regulation should be applied for the installation? Here the legislative discussion could be applied. As just described, several different factors should be considered for discussing the well-being of persons with disabilities. Naturally, nontraditional models have considered solving the puzzles of analyzing the lives of persons with disabilities.

The history of nontraditional models is the history of the trials and tribulations for seeking balance. It is important to note that the practices in many different disciplines are the basis of the development of nontraditional models. It is easy to ignore those models and to limit the models to the medical model and the social model. However, as civil society is developed further, learning from the development of nontraditional models, at least, is suggestive for the practitioners and scholars regarding their practices and research.

6. Conclusion

This paper discussed interdisciplinary models of disability. As discussed earlier, models of disability have been introduced in several different contexts. Although the social model and medical model are the majority models in the scholarship of disability research, it is necessary for

practitioners and scholars to maintain cross-border dialogue for achieving the well-being of persons with disabilities.

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障害モデルの特徴と分類

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【要旨】

実践者や研究者が障害にかかる実践や研究に携わるには、障害モデルを持つことが重要である。障害モデルとは障害に対する明確な視点であり、これを持つことがよりよい実践や研究につながるためである。また、人々の視点の相違がその人の障害観に変化をおよぼすことから、障害モデルを特徴づけることが重要である。本稿は先行研究文献のレビューをもとに、伝統的および非伝統的な障害モデルを、特徴づけの枠組みを用いて検討する。

先行研究により提示された枠組みを結合し、本稿は障害モデルを特徴づける属性を提示する。医学的診断、生活の質に対する自己認識、支援ニーズ、対人関係への関心、社会的抑圧への関心、個人・障害・機能の関係、そして法的関心の7属性である。

もっとも古い障害モデルは宗教的思想に基づくものであり、『宗教モデル』と呼ばれる。このモデルにおいては、障害はキリスト教の観点からは神からの罰であると考えられ、イスラム教の観点からは神から人間に与えられた挑戦と捉えられてきた。そしてこのモデルは慈善運動の根拠となり、現在も社会に残っている。このモデルの特徴は、生活の質に対する自己認識、支援ニーズの二つである。

一方、医学モデルが医学系実践者の間で支配的な存在となった。医学モデルとは、障害の原因を個人の医学的欠損に求めるものであり、医学的診断と支援ニーズに重きを置く。

また、医学モデルへのアンチテーゼとして、障害者権利運動に端を発する社会モデルが創出された。社会モデルの特徴は研究者によって多様である。いずれの研究者により提示された社会モデルにおいても、生活の質に対する自己認識、支援ニーズ、対人関係への関心、社会的抑圧への関心、個人・障害・機能の関係、そして法的関心のうち複数の要素を含む。

現在では医学モデルと社会モデルが主要な障害モデルと考えられているが、医学モデルが社会現象への関心を持たず、社会モデルが医学的欠損への関心を持たないという問題がある。その状況下において、非伝統的な『ハイブリッド的』障害モデルが様々な学問領域において構築されてきた。これらのモデルの特徴は横断的であり、いずれも医学モデルと社会モデルに有している特徴を部分的に包摂している。ただし、その特徴の包摂の度合いはモデルによって異なり、医学モデルか社会モデルのいずれかに類似しているものもある。

また、本稿は障害の理論研究において比較的関心を持たれてこなかった自閉症スペクトラムと言説分析への障害モデルの応用についても議論する。

キーワード：障害モデル、医学モデル、社会モデル、非伝統的モデル、特徴づけの枠組み