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UNIT 1. MEDIA ACCESSIBILITY

ELEMENT 1. HUMAN DIVERSITY

DISABILITY MODELS

Video Lecture Transcript

Slide 1

This is unit 1, Media Accessibility; element 1, Human diversity; video lecture, "Disability models". I am Anna Matamala, from Universitat Autònoma de Barcelona.

Slide 2

And in this video lecture I will be talking about different models that have addressed the concept of disability.

Slide 3

I will use three articles as main sources. An article by Maria Berghs, Karl Atkins and Hilary Graham entitled "Scoping models and theories of disability". An article by Pilar Orero and Irene Tor-Carroggio: "User requirements when designing learning e-content: interaction for all". And an article I co-authored: "User-centric approaches in access services evaluation: profiling the end user".

Slide 4

The oldest paradigm for understanding disability in the Western World is the moral model, which is based on religious beliefs. Disability is linked to sin and shame, and is viewed as a test of faith. The social reply to disability is charity and condescencion.

Slide 5

The medical model defines disability as a biological pathology that needs to be fixed. This approach has been useful to improve medical diagnosis and treatment, but it has also led to an unbalanced situation where doctors are the experts and patients are passive individuals.

Slide 6

The social model of disability developed in the 1960s and 70s in the UK in opposition to the medical model makes, and I quote, "a distinction between disability as the expression of oppression and disadvantage, and impairment as a physical, sensory, cognitive or mental health condition". That was a Berghs quote. The focus moves from the person to society: disability is not caused by individual impairments but by society failing to consider these individual differences. This model, too, does not come without criticism.

Slide 7

The human rights model tries to overcome both the medical and the social model, and is viewed as a tool to implement the UN CRPD, the United Nations Convention on the Rights of Persons with Disabilities. Human rights approaches use person-first definitions and establish legal,

political, cultural, social and economic rights. Person-first language means that we talk about "persons with disabilities", in contrast with expressions where the disability comes first ("autistic boy", for instance).

Slide 8

The International Classification of Functioning, Disability and Health (ICF, for short), approved by the UN World Health Organization in 2001, embodies what is now called the biopsychosocial model. This is a combination of the medical and social approaches to disability. It was a response to the over-medicalization of the International Classification of Impairments, Disabilities and Handicaps (ICIDH, for short) and the tendency of the social model to disregard biomedical origins of disabilities. This model sees disability as an interaction of physical, psychological and social factors, and is translated into the World Health Organization's Disability Assessment Schedule, now in version 2.0.

Slide 9

More recently, the human development model has been proposed by Sophie Mitra using Martha Nussbaum and Amartya Sen's capability approach. Disability can be understood, and I quote Mitra (2017), as "a deprivation in terms of functioning(s) and/or capability(/ies) among persons with health deprivations". For Mitra, health deprivations include impairments and health conditions, which are defined using the World Health Organisation's definitions. Capabilities refer to practical opportunities. Functionings refer to achievements.

Slide 10

According to Mitra, and I quote, "[d]isability results from the interaction between resources, personal and structural factors, and health deprivations. Disability identifies a specific type of deprivation or disadvantage that might be the target of policies". In Mitra's terminology, personal factors may be, for instance, age or sex, and they interact with health deprivations. Resources refer to goods, services or information owned by or available to the individual. Structural factors refer to structural constraints, for example in the physical environment, social attitudes and laws, systems, culture, etc.

All these factors impact on the wellbeing of the individual. As put by Mitra, and again I quote, "health deprivation is a necessary but not a sufficient ingredient for a disability. With this definition, not all persons with impairments/health conditions experience disability, but all are at risk of disability".

Slide 11

Let's refer to one example suggested by Mitra in her article. Two old men may have limited mobility. This would be a health deprivation, in her terminology. Both have similar functionings (that is, achievements): they are not working. However, they may have different capabilities (that is, opportunities) depending on their personal and structural factors.

Slide 12

For example, one man may have grandchildren he wants to take care of (this is a personal factor) and has the necessary means to stop working (that is, the resources). He could continue working if he wished to do so,

because he has different job offers (that is, structural factors), but he decides to stop working (that is, his achievement).

On the contrary, another man may want to work, but no one is willing to employ him owing to his age and limited mobility. The result, the outcome, the functioning, is the same: they are not working; but the capabilities, that is the opportunities, are different.

Well, this has been a necessarily simplified categorization and description of various disability models. I encourage you to discover other categorisations, read more about different models and find out all the nuances behind each of them.

Slide 13

This video lecture has been prepared by Anna Matamala, from Universitat Autònoma de Barcelona. You can reach me at anna.matamala@uab.cat.

Slide 14

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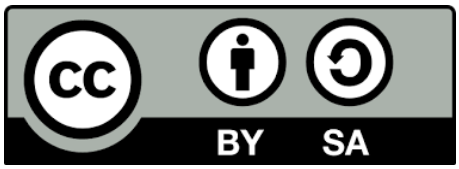

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