40 Stephen J. Macdonald and Lesley Deacon: Disability theory and social work practice

# Introduction

This chapter presents a summary of disability theory with reference to social work practice. We consider five models of disability, of which we advocate that three are essential for social work practice to support disabled service users. We discuss two medical models and three versions of the social model with reference to their theoretical origins. The chapter will suggest that the biomedical models employ an essentialist perspective to disability and impairment (see Chapter 6); whereas the social models draw on historical materialism, critical realism and post-structuralism philosophies. We use examples from our research to illustrate how these theoretical lenses emerge and can be applied in different situational professional spaces.

We argue that social work practitioners should not be constrained by one theoretical perspective. Rather, an eclectic toolkit should be utilized to facilitate inclusive and anti-discriminatory practices (Deacon & Macdonald, 2017). A post-positivist perspective is employed to bring together the different models by using a mixed-method approach in our research which is presented in this chapter. Thus, we exemplify our theoretical, qualitative and quantitative research to progress a social scientific approach in disability studies to inform social work practice. As Williams (2003) suggests, a post-positivist position has now been embraced, i.e. that both a positivist *and* interpretivist position can be occupied. This pragmatic approach therefore acknowledges that some ‘realities’ can be counted and measured and some cannot (Patton, 2002). The chapter aims to give clear direction for social work practitioners to understand different models of disability to develop a critical practice to move away from the current medicalized healthcare approach that dominates contemporary social work.

# Medical **models of disability and impairment**

In the UK, social work emerged from 19th-century philanthropy, which had a significant influence on the lives of disabled people, particularly individuals living in poverty (Bamford, 2015). Although historical definitions of disability are usually affiliated with the rise of clinical medicine through normative measurement of the body; charitable organizations also allied themselves to medicine. The rise of modern medicine firstly led to the categorization of human physiology through the notion of ‘normal’ and ‘abnormal’ biological function; and secondly an attempt to develop successful interventions to ‘cure’ these biological abnormalities (Barnes, 2010; Barnes & Mercer, 2010). By the late 19th century, these normative measurements were extended beyond the physical body to pathologically categorize ‘abnormal’ behaviours, i.e. mental health issues; and ‘abnormal’ intellect, i.e. learning or intellectual impairments (Barnes 2010; 2012; see Chapter 41). It is these early clinical definitions that led to the formation of the biomedical model in the 20th century. Charitable organizations in the late 19th and early 20th centuries, rather than reject biomedical movements such as eugenics, actively engaged with these practices (Simmons, 1978; O’Brien, 2011). With the emergence of medical social work in the early 20th century, the Biomedical Model became enshrined within social work practice concerning disability (Oliver, 1983).

## The biomedical model of disability

In social science, the biomedical model can be characterized as an essentialist theoretical perspective. This model uses positivist methodological techniques to collect statistical measurements of human pathologies through the notions of ‘function’ and ‘dysfunction’. From this essentialist perspective, the impairment impacts on ‘normal’ behaviours, restricting interaction and social participation resulting in disability. Hence, impairment is directly linked to disability due to a physiological or neurological ‘dysfunction’. With reference to professional practice, this model was defined by WHO’s ‘International Classification of Impairments, Disabilities and Handicaps’, in the 1980s, as:

Impairment: any loss or abnormality of psychological, physiological or anatomical structure or function.

* A deviation from a statistical ‘norm’ in an individual’s biomedical status
* Includes loss/defect of tissue-mechanism-system-function
* Temporary or permanent

Disability: any restriction or lack (resulting from impairment) of the ability to perform an activity in the manner or within the range considered normal for a human being.

* Functional limitation expresses itself as a reality in everyday life
* Tasks, skills, and behaviour
* Temporary or permanent (adapted from Semple, Smyth, Burns, Darjee & McInrosh, 2013, p. 90).

Although WHO has now replaced this classification, it still appears in prominent contemporary clinical medical texts (see *Oxford Handbooks of Psychiatry and Clinical Medicine*; *Oxford Concise Medicine Dictionary*). The model conceptualizes disability through a disease approach where the role of professional practice is to ‘cure’ or to ‘normalize’ the physiological or psychological defects of a condition. Although the role of the social worker does not directly engage in the concept of ‘cure’, practitioners often work alongside health care to facilitate treatment. For example, social workers may support a service user into a NHS residential care home or ensure that a person is complying with their prescribed psycho-pharmaceutical medications. This would be justified, as conditions like schizophrenia are conceptualized as health conditions which need medical treatments. As Maynard, Boutwell and Vaughn (2016, p. 5) suggest:

While schizophrenia is now understood as a disorder of brain function … research examining the contributions of biological and social factors has also led to a better understanding of the role and interaction of socio-environmental factors in the course of schizophrenia…. Thus, while understanding the biological factors is important, turning our attention to include biological factors in social work… does not presume a biological intervention. Indeed, it can lead to the identification and refinement of psycho-social interventions that affect or mitigate biological factors.

Applying a biomedical approach within social work practice employs a rehabilitative perspective which normalizes the disabling factors experienced by service users. In allying themselves to medicine to reduce a person’s impairment effect, social workers assist in the rehabilitation process and support medical interventions. For some service users, rehabilitation *may* lead to ‘cure’ which is the desirable outcome. Yet for most disabled people, impairment is permanent and ‘cure’ is not possible as their bodies have permanently changed or are physiologically different.

## The biopsychosocial model of illness, impairment and disability

Within the UK, and globally, the biopsychosocial model has become the dominant approach when theoretically conceptualizing disability, both in healthcare and in social work practice (Barnes, Green & Hopton, 2007; Berzoff & Drisko, 2015; Shakespeare, Watson & Abu Alghaib, 2016). This model developed from the work of George Engel, a psychiatrist, who viewed the biomedical model and social constructionist approaches as reductionist in nature. For Engel, the biomedical model reduced disease entirely to the molecular level and left no possibility for social factors to be incorporated within professional practice (Engel, 1977). Engel also rejected the anti-psychiatry movement of the time that dismissed entirely any biological causation of mental illness (see Szasz, 1961). In a 1977 article entitled ‘The need for a new medical model*’,* he suggested that illness is affected by social environments and biochemical changes within the body, which have a psychological impact on a person’s wellbeing. Engel proposed a need to develop an updated biomedical model which incorporated the biological, psychological and social.

The biopsychosocial model is still founded within an essentialist theoretical perspective, since it does not reject the concept that it is a person’s biological ‘function’ or ‘dysfunction’ which disables. However, this model advocates that the onset of illness, impairment and disability is complex and is affected by multiple different sociological and psychological factors. Conditions like schizophrenia cannot be entirely reduced to a biochemical deviation experienced by an individual. From the biopsychosocial perspective, the onset of schizophrenia *will* have occurred due to biological conditions, i.e. biochemical genetic properties. However, harmful behaviour may also have triggered the condition, i.e. experience of abuse or substance misuse. Certain social situations may also leave particular groups at greater risk of experiencing these harmful behaviours. As White (2005) illustrates, the biopsychosocial approach is holistic and examines the causal links between the biological, psychological and social to comprehend the onset of disease, illness and impairment. An example of this can be viewed in the work of Garland and Howard (2010):

The social work profession’s historical emphasis on the social environment as the context for individual wellbeing is supported by research over the past decade. Neuroplasticity and psychosocial genomic research indicate that socioenvironmental forces have the potency to alter human wellbeing through their effects on neurobiology…. Indeed, Engel’s biopsychosocial paradigm is rooted in the philosophical principle of complementarity … instead of the “either/or” mentality of dualistic reductionism, biopsychosocial research should embrace a “both/and” logic, where reports of subjective experience garnered through validated instruments and qualitative interviews are correlated … [This] can add value to Social Work as a primary mental health and allied-health profession (Garland & Howard, 2010, pp. 8–9).

As with the biomedical approach, social work practitioners work alongside health professionals; this time to employ a holistic approach to support service users. Healthcare professionals provide appropriate medical treatment which is supplemented with a care package. The role of the social worker enables appropriate care packages to support a service user’s biological (medical), psychological (psychiatric, also medical) and social (social care) needs. Garland and Howard (2010) argue that this model targets the complex and multiple needs of disabled service users to develop an appropriate and effective care model.

Yet the key criticism of this approach is that it individualizes disability and cultivates care packages designed around a person’s impairment type. Therefore, a service user who has recently experienced a permanent severe spinal fracture may: receive pain relief through medical services; get access to assistive technology such as a wheelchair; require environmental changes within the home; and receive some social care home support. If the person is struggling emotionally to deal with the loss of mobility they *may* also get access to psychiatric services. Although biopsychosocial practice does provide individualized support, it does not deal with the structural inequalities that, for example, a wheelchair user will face within the wider social context. Thus, the biopsychosocial model *still* medicalizes the experiences of disabled people.

**Social models of disability and impairment**

The social model of disability has become a significant model within social work practice since Oliver (1983) first defined this approach in his book *Social Work with Disabled People*. Since its emergence in the 1980s, and the formation of ‘disability studies’ as an academic field of inquiry, this approach has led to the rise of what is now defined as disability theory. Since the turn of the 21st century, disability studies have witnessed the emergence of three significant theoretical approaches. These have transformed the social model of disability and led to the formation of alternative models (Barnes, 2012). The social model of disability was originally underpinned by a historical materialist perspective, as disability was conceptualized as emerging from social and economic structural barriers which exclude disabled people. As the social model focused entirely on disability (i.e. structural disabling barriers), one of the key criticisms was its lack of attention to the effect that impairment has in a person’s life (Shakespeare, 2013).

This criticism has led to the development of two further theoretical approaches underpinned by post-structural (Goodley, 2014) and critical realist theory (Shakespeare, 2015). Hence the inclusion of impairment became a central concern within disability studies. From the poststructuralist perspective, not only is disability a social construct but so is impairment. This draws on a linguistic interpretation of disability and impairment, suggesting that both concepts are cultural constructs of medicine based on dialectic binary notions of normative cultural constructions of the body (Goodley, 2014). Critical realism, in contrast, argues for incorporating the concept of biological impairment within a disabling barrier approach, developing an interactionist approach where disability and impairment interrelate (Shakespeare, 2013).

Within disability studies, there has been a significant amount of debate concerning the most effective theoretical approach when conceptualizing disability and impairment within theory and practice. Yet, we suggest that social work practitioners are not constrained to one theoretical perspective, and should employ an array of approaches to inform practice. The popularity of the biopsychosocial model in social work practice may give the impression of a holistic approach, but this perspective is dominated by a biomedical ideology of disability, and this results in the medicalization of people’s abilities and inabilities through professional practice (Oliver & Sapey, 2006; Barnes & Mercer, 2010). We suggest that using different disability studies theories and models can offer social work practitioners different perspectives to embed the *social* rather than the *pathological* explanations of disability. A social worker should demonstrate sociological expertise aimed at understanding, intervention, support and inclusion for service users (Deacon, 2017).

In the following sections, we use examples of our own research, demonstrating how different models and theories of disability can be used to conceptualize the complex nature of support for disabled service users within society. We do not attempt to merge each model of disability, but argue that each model is effective depending on the nature and circumstances of a specific service user group; due to the eclectic nature of social work practice (Deacon & Macdonald, 2017).

## The social model of disability and historical materialism

The social model of disability initially developed from grassroots disability politics in response to the biomedical model which dominated health and social care in the 1970s and 1980s (Oliver, 2009). The early definition of the social model emerged from an activist group founded by Paul Hunt and Vic Finkelstein called the Union of the Physically Impaired against Segregation (UPIAS). Finkelstein and Hunt suggested that medicine offered them no solutions for overcoming problems associated with their impairments. Both men were wheelchair users, and proposed that the problems they experienced were not due to their ‘dysfunctional’ bodies but rather due to environmental issues that excluded and oppressed them, and other disabled people in society.

Oliver (1983) used UPIAS’s definition of impairment and disability to identify the ‘social model’ for social work practitioners. His later work expresses a clear definition of the social model:

Disability: a disadvantage or restriction of activity caused by a contemporary social organization which takes no or little account of people who have…impairments and thus excludes them from the mainstream of social activities (Oliver, 2009, p. 42, adapted)

From this perspective, the problems that disabled people experience are not due to functional limitation but due to environmental factors that prevent people, with a range of impairments, from fully participating in social life. The model was originally designed for people with physical impairments. By the 1990s, however, this expanded to people with sensory as well as intellectual impairments, followed later by individuals from the neuro-diversity and mental health communities. As Barton states:

An extensive range of research findings has demonstrated the extent of the institutional discrimination which disabled people experience in our society. This involves access and opportunities in relation to work, housing, education, transport, leisure and support services. Thus, the issues go far beyond the notion that the problem is one of individual disabilist attitudes. These are … structured by specific, historical, material conditions and social relations. Goodwill, charity and social services are insufficient to address … [these] factors (Barton 1993, p. 242).

The social model led to the formation of disability studies, underpinned by a historical materialist approach. A key element of this was to represent the voices and experiences of disabled people. This directly critiques the biomedical model as a system of social exclusion or oppression, which individualizes the social problems experienced by disabled people. An example of this can be seen in our research (Macdonald, 2009; 2012) on the impact that dyslexia has on adulthood. What was significant was the intersectional relationship between disabling barriers and social class inequalities. The research illustrated how people from lower socio-economic backgrounds experienced additional disabling barriers than their middle-class counterparts. This was particularly relevant for the group of participants who had engaged in criminality. Macdonald (2012) identified that the overrepresentation of service users with dyslexia in the criminal justice system was not due to a pathological link between dyslexia and criminality (Dåderman, Meurling & Levander, 2012), but rather to structural inequalities. He suggests that more affluent participants had increased access to educational support and knowledge of assistive technologies, allowing them to confront many of the disabling barriers experienced in education and later in adulthood. Macdonald and Clayton (2016) later explored the relationship further between disability, technology and socio-economic status. They found that disabled people had access to less technologies than the non-disabled population and therefore were unable to perceive them as helpful in addressing disabling barriers.

[F]rom an individual model perspective … the ability to use ICT depends on impairment (i.e. visual, hearing, motor and cognitive, etc.). Someone with no functional vision is more likely to experience difﬁculties using the Internet than someone with restricted lower body movement …. [A]lthough impairment impacts on how individuals use technology, the authors have presented evidence that there are structural barriers, such as poverty, skills/knowledge and inaccessibility, which prevent disabled people in this study from using a range of digital technologies. … Therefore, if access to digital technologies is only for people who can afford them, then digital and assistive technologies, rather than beneﬁt disabled people, will create a new level of social inequality reinforcing the digital divide within the United Kingdom. This study concludes by … claim[ing] that access to digital technology that helps remove barriers of exclusion for disabled people should be seen as a ‘right’ rather than a privilege for disabled people (Macdonald & Clayton, 2016, pp. 128-9).

Because social workers engage in practice at a micro level, they often miss the macro level (see Chapter 29). The social model enables them to understand what is needed (macro) rather than what is available (micro). These research examples illustrate the intersectional relationship between poverty and disability, and as Oliver (2009) suggests, if interventions are developed based on impairment (biomedical), this leads to a one-size-fits-all approach. Our research highlights, however, that people with the same impairment experience very different disabling barriers depending on their social and economic backgrounds. For example, a disabled person from an upper-middle-class background can afford to purchase additional assistive technologies, while those from a lower-class background are subject to what is available through the NHS (Macdonald, 2009; Macdonald & Clayton, 2016). Therefore, their experience of disability is completely transformed by their social position. This requires social work practice to focus on disabling barriers rather than impairment type to take a truly service user perspective.

## The social relational model of disability and critical realism

Within the UK, by the 21st century, the social model of disability had offered an alternative theoretical lens through which to conceptualize disability, which transformed research and social work practice (Macdonald, 2017). However, during this time the social model began to attract several criticisms. The first significant critique of the social model could be seen in the work of Liz Crow (1994), a disability activist. She acknowledged the importance of the social model in redefining disability, and suggested that it had transformed her identity from a person with a dysfunctional pathology to an individual who belonged to an excluded minority group. She illustrated, however, that although the social model was directed at macro structural inequalities, it completely overlooked the concept of impairment.

In fact, impairment, at its most basic level, is a purely objective concept which carries no intrinsic meaning. Impairment simply means that aspects of a person’s body do not function or they function with difficulty. Frequently this has taken a stage further to imply that a person’s body, and ultimately the person, is inferior. However, the first is fact; the second is an interpretation (Crow 1994, p. 211).

For Crow, impairment-related issues, such as pain or fatigue, had a significant impact on her experience of disability, so she argues for the necessity of incorporating impairment within the social model of disability. Shakespeare and Watson (2001) then described the social model as an ‘outdated ideology’. They suggested that, to develop a theory of disability,

one must incorporate both disability (as structural inequalities) and impairment (as a physical limitation). Shakespeare and Watson (2001) argued for a dualist perspective, therefore: disability and impairment interact, resulting in disabling factors that impact on disabled people’s lives.

Experientially, impairment is salient to many. As disabled feminists have argued, impairment is part of our daily personal experience, and cannot be ignored in our social theory or our political strategy. Politically, if our analysis does not include impairment, disabled people may be reluctant to identify with the disability movement, and commentators may reject our arguments as being ‘idealistic’ and ungrounded. We are not just disabled people, we are also people with impairments, and to pretend otherwise is to ignore a major part of our biographies

(Shakespeare & Watson, 2001, p. 11).

Shakespeare (2013) later argues that pain is a significant disabling factor that impacts on people’s lives. In his work we see the emergence of critical realism within disability studies. From this perspective, disability is constructed through structural barriers, and impairment relates to functional difficulties, which impacts on an individual’s daily realities. Shakespeare draws on the work of Danermark (2001) and Bhaskar, Danermark and Price (2017) suggesting that different levels of reality exist concerning disability and impairment. For others, the critical realist approach has been adopted as the ‘social relational model of disability’ (Ferrie & Watson, 2015). This was initially defined by Thomas (2007) to complement the social model by incorporating the emotional experiences of disability.

Examples of the social relational model can be viewed in our other studies. The impact of diagnosis and labelling is discussed with reference to dyslexia (Macdonald, 2010). In this research, a significant disabling barrier related to participants’ lack of access to a diagnosis. Macdonald (2010) rejects the concept that dyslexia is merely a social construct and argues that the condition is both socially constructed and exists as a biological reality. We argue that there is a reality which formed the social experiences of participants within this study, and those realities are constructed by the effects of disability *and* impairment. Macdonald and Deacon (2015) extended this study to employ a quantitative approach, exploring the lives of homeless service users with dyslexia from a social relational model perspective. This study illustrated that service users with dyslexia were more prone to long-term addiction problems, were more likely to be processed through the criminal justice system, and were at increased risk of self-harm and suicide attempts, when compared to the non-dyslexic homeless population. Yet, there had been no attempt to comprehend the impact that dyslexia had on this group. Macdonald and Deacon (2015) argued that social workers must understand the impairment effect, as this significantly impacts on the specific disabling barriers experienced by homeless people with dyslexia. They illustrated that participants did not have access to specialized adult services relating specifically to their dyslexia; many service users had access to mental health and drug and alcohol support, yet dyslexia went completely unnoticed in social work practice.

[P]eople with dyslexia are overrepresented within the homeless population in the UK. As demonstrated, a number of statistically significant relationships have appeared within the data findings. These findings seem to suggest that for participants with dyslexia, once they become homeless, they have an increased risk of spiralling into the episodic and chronic homeless population. This study does not reject the importance of current support packages with reference to financial stability, drug and alcohol services and mental health support …. However, there also seems to be a need for specialist forms of support for dyslexia which is demonstrated in the findings; which requires further research

(Macdonald & Deacon, 2015, p. 89)

Macdonald and Deacon (2015) argued that participants with dyslexia experienced significant disabling barriers in adulthood, but these barriers were impairment-related. A key problem for this service user group, therefore, was a lack of services that concentrated on impairment-specific barriers in adult life.

Although Shakespeare (2013) argues for the discontinuation of the social model, replacing it with a social theory, we argue that both models can be useful in different practice settings; taking the social work eclectic approach (Deacon & Macdonald, 2017). From this perspective, the social model of disability is effective when dealing with universal structural barriers, whereas the social relational model can be employed to conceptualize the disabled people’s embodied experiences of disability and impairment.

*Cultural disability studies and the affirmation model of disability*

Further significant critiques of the social model of disability emerged from a cultural perspective, drawing on post-structuralism as a critical linguistic analysis of disability and impairment. From this perspective, impairment, along with disability, is socially constructed; this differs significantly from the critical realist perspective. Cultural disability studies have been considerably influenced by writers such as Davis (1995), Corker (1999) and Goodley (2011). Disability and impairment are conceptualized as linguistic constructs arising from social, economic and cultural ideas at a particular point in time. From a cultural disability studies perspective, medical diagnostic labels are attached to bodies and are medically referred to as impairment types. These labels are not universal, or inevitable, but linguistic cultural constructs of a society that problematizes biological abilities due to their economic and cultural value. Medicine presents these diagnostic labels as scientific and objective, but cultural disability studies proposes that these labels are produced within a socio-cultural political landscape.

This uneasy transhumanist dance between the binaries of disability/normalcy, deficiency/capacity, essentialism/freedom of choice demonstrates the ethically questionable ambitions of human enhancement when the erasure of disability is implicated. While disability studies recognises the disavowal of disabled people as rejected citizens of wider society, critical ableist studies questions transhumanist ambitions around human improvement and the negation of limited normal humanness (Goodley, 2014, p. 25).

For Goodley (2014), disability is conceptualized through linguistic binary notions of ‘normality’ and ‘abnormality’, which are products of bourgeois moralities. This is justified through medical language which dissects disability into impairment categories, and justifies those categories through discourses of universalism and science. Foucault’s (2003) work is influential on this approach, as medicine is an institution of power, which manufactures discourses that categorize physical variations through normative biological measurements (Goodley, 2014). This ‘medical gaze’ exercises power over its cultural subjects as a system of social control. Therefore, impairment categories exist due to the political, cultural and economic need for particular labels at any given time.

This poststructuralist perspective offers the most radical interpretation of disability and impairment. It develops an oppositional discourse, thus rejecting terms like disability and disablism and replacing them with the concept of ableism. From Goodley’s (2014) perspective, disability is now a construct of neoliberalism, and so the cultural production of this discourse must be examined. Drawing on this perspective, we have applied this radical approach to the study of mental health within social work practice. Macdonald, Charnock and Scutt (2018) explored the lived experiences of service users who had been diagnosed with a significant mental health problem. These service users had been engaging with services since the 1970s and ’80s, and the research explored how service user lives have changed after deinstitutionalization of care within the UK. The study discovered that discourses around care had changed, but the majority were still living within an institution, i.e. residential care, as well as taking a range of psycho-pharmaceutical medication.

Although, contemporary psychiatry refers to the dismantling of mental hospitals through the process of deinstitutionalisation …, there seems to be evidence in this study that there is still the reminiscent of the old hospitals in the current care system. In this study, the long term housing of economically deprived mental health patients is no longer delivered by the hospital, but now is provided by a privately run residential care system. Based on the majority of service user/survivor experiences, the marketisation of mental health services seems not to have led to the deinstitutionalisation of care, but has resulted in the process of trans-institutionalisation where service users/survivors have been moved from state owned to privately run care units (Macdonald et al. 2018, p. 27)

In this study, service users’ lives were significantly affected by institutional environments which controlled every aspect of their lives administratively. Although service users were free to leave their institutional care homes at any time of the day, few reported engaging in any activities outside the residential setting. Although the discourse of ‘cure’ was discussed, participants had been receiving medication as a form of therapy for 30 to 50 years. The key conclusion of this study was that although the large mental hospitals were closed during the period of deinstitutionalization, these were replaced by smaller residential care homes within the community. Therefore, the discourse of institutionalization has changed but the practice has stayed the same. Macdonald et al. (2018) found that the discourse of ‘cure’ was used to justify the use of medication over a long period of time, and in an institutional setting. Hence, the discourse of ‘cure’ has developed into a practice of social and political control.

Although cultural disability studies offer a radical perspective to question every aspect of medicalization, this approach can be associated with the development of the affirmation model of disability. Although initially defined by Swain and French (2000), Cameron (2011) provides a clear definition. For him, the construction of normality is a cultural performance which relates to a given set of societal norms. Within bourgeois culture, normality is celebrated where dis/ability is commiserated. Drawing on a linguistic perspective, this model confronts negative connotations associated with dis/ability as a tragedy in order to celebrate dis/abled people through minority status.

Disability [refers to] a personal and social role which simultaneously invalidates the subject position of people with impairments and validates the subject position of those identified as normal (Cameron, 2011, p. 20)

From this perspective, the dis/abled pathologies are constructed through the notion of abnormality, therefore validating the role of normality in society. Linguistic norms are produced in a historically specific cultural setting. So, for Cameron, if disability and impairment are culturally and historically constructed then in effect this can be changed. He conceptualizes impairment through the notion of *difference* rather than as a personal and *social tragedy*.

From a social work perspective, cultural disability studies offer a radical critical discourse which questions all aspects of professional practice concerning disability. For the most part, this criticism has developed with reference to mental health services, particularly around medication and hospitalization (LeFrancois, Menzies & Reaume, 2013; LeFrancois 2017). Again, social work is viewed as an ally of medical practice and engages in dominant medical discourses which exercise disciplinary power to make service users engage with (pharmaceutical) treatment and place many disabled people in institutional settings (Macdonald et al. 2018). Not only does a cultural disability studies perspective offer social work a critical tool kit to interrogate concepts such as disability and impairment within professional practice, but it also gives us a model that can celebrate human and biological diversity within society. From this perspective, as culture constructs notions of disability and impairment, then these meanings can be altered through radical ideas and practices.

# Conclusion

The aim of this chapter is to present a range of perspectives which allow social work practitioners to understand and apply different theoretical lenses to support disabled service users and develop services. The chapter has outlined the dominant biopsychosocial approach which is employed globally within social work practice. We have suggested that this model is an extension of the traditional biomedical approach in contemporary practice. The biopsychosocial model, we argue, medicalizes service users’ abilities and inabilities by conceptualizing disabilities through the notion of pathological dysfunction. This also allows an over-simplistic approach, which reinforces the current neoliberalization of social work practice, meaning that social work practitioners manage disability through services aimed at the biological (medicine), the psychological (psychiatric services) and the social (social care). From this position, the social work practitioner may perceive that they have successfully assessed and commissioned services based on a holistic approach to support the needs of a disabled service user. However, as medicine dominates, this applies a disease model in treatment and support of people with a range of impairments. We argue in this chapter that, although the biomedical has been renamed as the biopsychosocial model, this operates to individualize and medicalize social work practice.

Although we have illustrated the biomedical models, we do not advocate the use of these approaches for practice. Rather, we have presented examples of the authors’ research which identifies alternative approaches to conceptualizing and supporting disabled people within the community, based on social models of disability. These models, which have emerged from disability studies, are often presented as opposing theoretical perspectives when defining disability. The authors argue, however, that these approaches can be complementary if used as part of the practitioner’s eclectic toolkit. As Deacon (2017) suggests, social work theory consists of a range of possibilities, from neoliberal individualism to radical psychological and sociological constructionism. The aim of the social work practitioner is to devise and apply an eclectic toolkit to understand behaviours and facilitate effective and inclusive interventions; achieved through anti-discriminatory practice. Practice *must*, however, be facilitated by theoretical perspectives that are grounded within research (Deacon and Macdonald 2017); as demonstrated in this chapter.

Shakespeare (2018) argues that disability studies have progressed in three waves, the first is the formation of the social model (in the work of, for example, Barnes, Finkelstein, Oliver); the second refers to debates around the impact of impairment (Shakespeare, Thomas, Watson); and the third to the cultural constructions of dis/ability and impairment (Davis, Goodley). This chapter proposes a fourth wave to disability studies based on a post-positivist perspective, where theoretical and qualitative explorations, using disabled people’s experiences, are quantified to progress representative evidence-based research to facilitate professional social work practice. Therefore, this study concludes by suggesting that the role of social work practitioners is not to be the silent partner of health professions, but rather to be social experts equipped to deal with complex social problems in everyday practice. What is unique about disability theory is that the theoretical knowledge which emerges from research has been produced, and is in partnership with, disabled people. The authors argue that rather than applying an updated biomedical model (i.e. the biopsychosocial model) to professional practice, social work practitioners can use a range of sociologically-informed theoretical perspectives to facilitate inclusion and social change for disabled service users.

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