Parenting and Disability - Defining disability

Midwives and other health professionals will meet parents with long term chronic health problems either in their home, health centre or in a hospital setting. You are likely to be familiar with sociological theories which include the biomedical model of care for example as discussed by Jones( 1997). Using this model it is believed that:

- Health is the absence of biological abnormality
- Diseases have specific causes
- The human body can be likened to a “machine” to be restored to health through personalised treatments that arrest, or reverse, the disease process
- The health of a society is largely dependent on the state of medical knowledge and the availability of medical resources

Although increasingly challenged in recent years, the biomedical model of health still underpins the organisation and delivery of health care in contemporary societies (Taylor & Field 2007:26). Through the application of the biomedical model our ability to manage chronic long-term conditions has become effective and the life expectancy of those with these conditions has been lengthened to the extent that many more sufferers now contemplate pregnancy and childbirth; for example, more women with chronic diseases such as cystic fibrosis are now able to contemplate pregnancy and childbirth. Women are surviving longer with cardiac disease, cancers and HIV but whilst surviving these illnesses some are left with chronic ill health (www.cmace.org) and need long-term medication and interventions over many years. In addition new guidelines have been introduced to improve care for pregnant women with complex social needs (www.nice.org.uk) including obesity and substance misuse.

Classification and definition of disability

Individual experiences of physical disability and chronic ill health are shaped by the society in which that person finds themselves.
Watson & Denny (cited in Denny & Earle 2009:140) discuss how 30 years ago “many disabled people would have been found in large, isolated, residential establishments” where “job opportunities for many were restricted to….sheltered employment with an emphasis on work as rehabilitation. These centres offered poor training, little opportunity for advancement and low wage levels. Disabled children were segregated from their non-disabled peers ……..this in turn served to deny them future opportunities. Disabled people were denied sexual rights, the right to form relationships, reproductive rights and the right to lead independent lives.”

The medical or individual model of disability
This approach sees:

- *impairments* as the result of a biological or psychological abnormality,
- *disabilities* are the resulting restriction in activity
- *handicaps* are the *disadvantages* faced by disabled people that arise as result of impairments or disabilities.

Impairment is therefore seen as the *cause* of the disadvantages faced by disabled people. (Watson & Denny (cited in Denny & Earle 2009:140).

The focus of care is to rehabilitate or cure the individual. The medical “expert” defines an individual’s needs, how these needs should be met and how the negative consequences of an individual’s disability can be minimised (Watson & Denny (cited in Denny & Earle 2010:140).

The social model of disability
Critics of the biomedical model have led the *WHO International Classification of Functioning and Disability* (WHO 1997,2002) to use terms such as “activity limitations” and “participation restrictions” when defining disability.

This clearly emphasises that we must look at the interaction between the disabled person and environmental factors. This includes disabling attitudes and architectural barriers as well as personal factors such as gender, age and social background (Watson & Denny (cited in Denny & Earle 2009:142). The social model of disability has been adopted by many disability rights groups.

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Morris (1993:x) would argue that there is a difference between the terms *impairment* and *disability* and used the following example to illustrate this point:

‘An inability to walk is an impairment, whereas an inability to enter a building because the entrance is up a flight of stairs is a disability. An inability to speak is an impairment but an inability to communicate because appropriate technical aids are not made available is a disability. An inability to move one’s body is an impairment but an inability to get out of bed because appropriate physical help is not available is a disability.’

**Defining Disability e-tivity (1 hour)**

**Task**

1) What do you think is the difference is between disability and impairment?

2) What effect does this have on care delivery?

3) Add you ideas to the…*(Note to facilitator - suggest a discussion board) (50 words)*

**Respond**

Comment on two other health care professionals contributions. Make sure you return to this activity to respond to other members of your team. (30 words each)

**References**


