Anteckningar från seminarium med Colin Barnes; Recent debates within the social model.

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Colins egna anteckningar som skickades ut inför föreläsningen:

**Understanding the Social Model of Disability**

*Background notes to a verbal presentation at*  
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**Introduction**

Although the phrase the ‘social model of disability’ first entered political and policy arenas in 1981, its intellectual foundations are firmly rooted in the political upheavals of the mid twentieth century and the politicisation of disability by disabled writers and activists in the early 1960s (Campbell and Oliver 1996). Often referred to as the ‘big idea’ of the disabled people’s movement (Hasler 1993: 80), social model inspired thinking has played a major role in the mobilisation of disability activism and, more recently, policy development in the UK and many nations across the world (Barnes and Mercer 2005). However, despite this apparent success there remains a general misunderstanding about what the social model actually is and what it represents. In this presentation, I shall address some of the issues that help perpetuate this unfortunate situation.
The traditional individualistic medical approach to disability

To understand the significance of the implications of social model inspired thinking it is important to remember that until very recently disability was understood almost exclusively as an individual medical problem or ‘personal tragedy’. Although there is a wealth of anthropological evidence to suggest that societal responses to people with impairments or long term health problems varies considerably across time, culture and location, this is the view that has dominated western society since at least the late eighteenth century. As a consequence disabled people were set apart from the ‘normal’ or ‘ordinary’ because they posed a direct challenge to commonly held values as: ‘unfortunate, useless, different, oppressed and sick’ (Hunt 1966: 146).

The individual ‘medical; medical approach to disability is commonly associated with the World Health Organisation’s (WHO) ‘International Classification of Impairment, Disability and Handicap’ (ICIDH). The ICIDH was developed during the 1970s by a group of social scientists led by Philip Wood. The aim was to clarify some of the concepts and terminology surrounding disability in order to facilitate research and policy in this increasingly important area. Since the ravages of the 1939/45 war many states had introduced welfare policies for ‘sick and disabled’ people but due to increased prosperity and medical advances the numbers of disabled people had increased substantially. Hence the need for accurate and comparable research had intensified at both the national and international levels (Bury 1997).

Designed to complement the WHO’s already established ‘International Classification of Disease’, the ICIDH construct is a threefold distinction between ‘Impairment Disability and Handicap. These were defined as follows:

- **Impairment** ‘Any loss or abnormality of psychological, physiological or anatomical structure or function’

- **Disability** ‘Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being’

- **Handicap** ‘A disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role (depending on age, sex, social and cultural factors) for that individual (Adapted from Bury 1997).’

Or, to put it another way, ‘impairment’ includes those parts or systems of the body which do not work ‘properly’, and ‘disability’ centres on those things that people cannot do, primarily basic skills of everyday living. Whilst acknowledging that these vary across social groups and cultural contexts, ‘handicap’ refers to the social consequences of either impairment or disability. The disablement process is represented in terms of distinctive but linked areas of consequences. Thus:
The ICIDH may be criticised on several levels. These criticisms may be summarised as follows:

- It relies exclusively on medical definitions and bio—physical assumptions of ‘normality’. But as numerous studies have indicated ‘normality’ is a highly contentious concept influenced by a variety of historical, cultural and situational forces.

- ‘Impairment’ is identified as the cause of both ‘disability’ and ‘handicap’. The latter is presented as neutral and the inevitable consequences of either impairment or disability. It is important to note here that not all impairments effect an individual’s physical or intellectual capability.

- The ICIDH approach places people with an actual or accredited impairment in a dependent position. Their condition is medicalized and therefore assumes that they are reliant upon professional experts and others to provide therapeutic and social support.

In short, as impairments are presented as the root cause of the problem of disability, logic dictates that they must be eradicated, minimised or ‘cured’. But where ‘cures’ are ineffective, which is more often than not the case, people with impairments and labelled ‘disabled’ are viewed as not quite whole, not ‘normal’, and incapable of participating in and contributing to the everyday life of the community. They are, therefore, in need of ‘care’. In many countries this has resulted in the generation of a thriving and costly ‘disability’ industry comprised of state institutions, private businesses, charities and voluntary organisations staffed by vast armies of professional helpers including doctors, nurses, therapists and social workers. The end result is that disabled people’s assumed inadequacy and dependence is assured and reinforced. These perceptions were not seriously challenged until the 1960s and the emergence of the disabled people’s movement.

The Social Model of Disability

As mentioned above disabled activism emerged in the middle of the twentieth century as a response to the various economic and social deprivations disabled people encountered in most western ‘developed’ industrial societies. In response disabled writers across the world began to focus their attention on the experience of ‘disability’ or ‘handicap’ as social oppression or institutional discrimination (see for example Höjer 1951: Hunt, 1966: Bowe 1978). Underpinning the political demands of disabled people and their organisations is a socio/political re-interpretation of disability commonly referred to today as the ‘social model of disability’. Originally devised by disabled activists in Britain this approach derives from disabled people’s direct experiences of living with impairment in Western society.
Undoubtedly the most influential organisation in terms of the history of social model thinking is the Union of the Physically Impaired Against Segregation (UPIAS). Established in 1974 it functioned mainly through confidential correspondence and circulars circulated amongst its members. This literature had to be confidential because many UPIAS members were living in residential institutions. The views expressed in UPIAS documents resulted in the production of the UPIAS Policy Statement and constitution first adopted in 1974 and later amended in 1976. A comprehensive discussion of the UPIAS analysis of disability is found in the ‘Fundamental Principles of Disability’ published in 1976 (UPIAS 1976). This document contains a socio political re-interpretation of disability that draws the crucial distinction between the biological and the social. Thus

Impairment’ denotes ‘Lacking part or all of a limb, or having a defective limb or mechanism of the body’

and

Disability’ the disadvantage of restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities (UPIAS 1976: 3 – 4).

In contrast to previous definitions UPIAS re-defined ‘disability’ as something imposed on top of people with ‘impairment’s’ lives, by a society that is intolerant of any form of biological flaw whether real or imagined (UPIAS, 1976) - the responsibility for the disadvantage experienced by disabled people is shifted from the disabled individual to the organisations and institutions of contemporary society.

In order to put this idea into practice, Mike Oliver coined the phrase the ‘social model of disability’ in 1981. It was used initially for the training of social workers and professionals working in the disability field (Oliver, 1981) and, later, as the main mechanism for delivering Disability Equality Training (Gillespie-Sells and Campbell, 1991) as opposed to ‘Disability Awareness Training which was usually constructed around traditional individualistic impairment specific considerations and concerns.

It is important to remember here what the social model actually is. It is a model, which is what social scientists call a ‘heuristic device’ or an aid to understanding. However, in view of recent misplaced statements about what the social model actually represents (Shakespeare and Watson 2002) it is necessary to restate the following:

- One, a social model perspective does not deny the importance or value of appropriate individually based interventions in the lives of disabled people, whether they be medically, re/habilitative, educational or employment based, but draws attention to their limitations in terms of furthering their empowerment and inclusion in a society constructed by ‘non-disabled people’ for ‘non-disabled’ people.
Two, in contrast to the conventional individual medical model of disability, it is a deliberate attempt to switch the focus away from the functional limitations of impaired individuals onto the problems caused by disabling environments, barriers and cultures.

Three, it is an holistic approach that explains specific problems experienced by disabled people in terms of the totality of disabling environments and cultures. This includes inaccessible education, information and communication systems, working environments, inadequate disability benefits, discriminatory health and social support services, inaccessible transport, houses and public buildings and amenities, and the devaluing of disabled people through negative images in the media – films, television and newspapers (Adapted from Oliver 2004).

In short, the social model of disability is a tool with which to gain an insight into the disabling tendencies of modern society in order to generate policies and practices to facilitate their eradication. It is not a theory although it has been the foundation for the development of a fully comprehensive materialist account as expressed in the work of Mike Oliver (1990).

However, it is often argued that the conceptual division between impairment and disability upon which the social model rests is false (Shakespeare and Watson 2002). But the UPIAS redefinition of impairment and disability was a deliberate attempt to separate the biological and the social. To suggest that such a distinction is false is like suggesting that the distinction between the individual and society is false. Whilst such assertions may be of interest to philosophers and some social theorists, I believe that they have little, if any, practical value in terms of research, policy and practice.

This is not to say that the term ‘impairment’ is not problematic since it is generally understood to refer to damaged or weakened bodies. It may be relevant when used in relation to someone’s reduced capabilities as a result of accident or illness, but is less so with reference to congenital conditions and those that do not affect people’s capacity to do things. Those of us born with impairment only usually realise we are ‘different’ when we come into contact with other ‘non-disabled’ people.

Moreover it is important to remember too that although originally limited to physical impairments, shortly after its development, the UPIAS definition was adapted and adopted by the disabled people’s movement, both nationally and internationally, to include all ‘impairments’: physical, sensory, intellectual.

Also integral to this re-assessment is the assertion that all physiological conditions have psychological implications and all psychological problems have physical consequences. It is therefore an inclusive concept that encompasses all sections of the disabled community including, for example, mental health systems users and survivors.

This is in recognition of the fact that labels are generally imposed rather than chosen, and, therefore, socially and politically divisive. It also encompasses,
implicitly if not explicitly, the notion that like ‘disability’ the meaning of ‘impairment’ is a social construct too. Indeed, a key feature of ‘social model’ literature is that ‘attitudes’ toward disabled people are historically, culturally and situationally determined (Oliver 1990: Barnes 1991).

**The Impact of Social Model Thinking**

There can be little doubt that the re-interpretation of disability as a socio/political issue coupled with social model insights has had a considerable impact on the disabled people’s movement both within and without the UK. Adopted by the British Council of Organisations of Disabled People (BCODP), Britain’s national umbrella for organisations controlled and run by disabled people themselves, and now known as the British Council of Disabled People, the social model became the rallying cry for disability activists across Britain in the 1980s and 90s. As the disabled writer Jenny Morris recently stated:

‘The social model of disability gives us the words to describe our inequality. It separates out (disabling barriers) from impairment (not being able to walk or see or having difficulty learning’)…. Because the social model separates out disabling barriers and impairments, it enables us to focus on exactly what it is which denies us our human and civil rights and what action needs to be taken’ (Morris 2000: 1-3).

Consequentially social model thinking and the emphasis on disabling barriers played a significant role in the mobilization of the disabled people’s movement and the various campaigns that have characterised disability politics and social policy in the UK over the last decade or so. Notable examples include the struggle for anti-discrimination legislation to outlaw unjustifiable discrimination against disabled people (Barnes 1991), and the campaign to legalise direct payments to enable disabled people to employ their own support workers (Zarb and Nadash 1995).

Furthermore, besides organisations controlled and run by disabled people (Barnes, Mercer and Morgan 2000) social model rhetoric, if not policy is now evident in the publications of a host of agencies dealing with disability and related issues in both the statutory and voluntary sectors across the UK. Examples include the Disability Rights Commission (DRC 2002), the Leonard Cheshire Foundation (Carmichael, Brown and Docherty 2000), NHS Trusts such as Liverpool NHS Primary Care Trust (Clarke 2002) and local authority social service departments like Leeds (LSSD 2001, 2003).

Internationally the UPIAS re-interpretation of ‘disability’ was adopted by the international disabled people’s movement, as represented by Disabled People’s International, in 1981; albeit the terms ‘disability’ and ‘handicap’ were initially substituted for the words ‘impairment’ and ‘disability’ because of concern over the term ‘impairment’ amongst some DPI delegates. However, DPI Europe subsequently reversed this substitution because of disquiet over the term ‘handicap’. Beyond the English speaking world the issue here is not necessarily the terms used but the meanings to which they are attached; in particular, the redefinition of disability/handicap as social oppression, and the adoption of a ‘social model’, or social/political analysis, of its origins, continuity and abolition.
The DPI’s influence at the international level, particularly, within the UN is indisputable. A social model perspective is implicit if not explicit in various UN documents. The UN (2003/4) ‘Standard Rules on the Equalisation of Opportunities for People with Disabilities’ is but one example. In terms of European Union EU policy as recent EU Action Plan clearly states there is now an EU ‘Social Model of Disability’:

‘The EU also sees disability as a social construct. The EU social model of disability stresses the environmental barriers in society which prevent the full participation of people with disabilities in society. These barriers must be removed’ (Commission of the European Communities 2003: 4).

Additionally, a social model perspective played a key role in the recent ‘Rethinking Care from Disabled People’s Perspectives’ sponsored by the WHO’s Disability and Rehabilitation Team; a two year project and conference that involved professionals, disabled people, and their families from all over the world (WHO 2001). Furthermore the WHO’s recently developed ‘International Classification of Functioning and Health’ (WHO 2005), also known as ICIDH-2, to replace the much maligned International Classification of Impairment, Disability and Handicap (ICIDH) also claims to incorporate social model insights into its construction (for an extensive of the ICF see Barnes and Mercer 2005).

**Final Word**

Despite the above it is important to remember that the apparent acceptance of social model inspired thinking within political and policy circles, both in Britain and across the world, has yet to be translated into meaningful and enforceable practical policies and practices. Although most nation states now have some form of anti-discrimination legislation to outlaw the various forms of institutional discrimination against disabled people that characterise many contemporary societies, progress is painfully slow.

The various laws and policies that have been introduced over recent years to address this problem are replete with accommodations and ‘get out’ clauses that render them almost ineffectual and unenforceable. This is especially evident with reference to those that deal with the physical built environment (Prideaux 2006) which, as long ago as 1982 was considered a, if not the, major barrier to disabled people’s autonomy and independence (CORAD 1982). The end result is that the majority of people with impairments continue to encounter a range of economic, political and cultural barriers to mainstream living that, more often than not, renders them economically and socially dependent on their families, their friends and society as a whole. Their continued existence serves only to inhibit the moral, cultural and economic development of nation states and, indeed, human society as a whole. The eradication of these barriers is long overdue.
References


UN. 2003/4: Enable: Standard Rules, Overview


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Understanding the Social Model of Disability

This presentation consists of four parts:

- Background
- Traditional individualistic medical approach to disability
- The social model of disability
- Doing Disability Research

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The Social Model of Disability and Research.

Explanation: DS means Disability Studies.

Anders Gustavsson: Welcome to Stockholm University. It’s a great honor to have Colin Barnes here with us! We are happy to join this kind of arrangements together with the Swedish Disability Federation. The project is a start of a small revolution for Disability Studies in Sweden.

Colin Barnes is the founder of DS in Leeds and professor of DS. Very few people are both pioneers and still working with the subject. The floor is yours!

Colin: Impairment refers to biological functions; the body as a biological being.

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**Background**

- Until the middle of the last century the traditional individualistic medical explanation for disability was unchallenged
- Social model inspired thinking is rooted in the political upheavals and civil rights struggles of the 1980s
- In particular the mobilisation and politicisation of disability by disabled activists and their organisations across the world
Individualistic medical approach to disability

- Impairment ---------
- Disability ---------
- Handicap ---------


About special schools: WHO (World Health Organization) in 1980 adopted the International Classification of Impairment, Disability and Handicap. Your impairments can make difficulties in connection with society or not. The medical professions doesn’t ignore this either. Being bald they study. Women for example; how would a big beard influence on their possibilities to get a job for example? Of course it should. There is a cultural dimension upon all this.

Problems with WHO’s ICIDH

- It relies exclusively on medical definitions and bio-physical assumptions of ‘normality’
- Impairment is the cause of both disability and handicap
- Handicap is presented as politically and culturally neutral and the inevitable consequences of impairment and disability
- People with impairments are assumed to be dependent on medical and rehabilitation experts for therapeutic and social support
- Policy outcomes include ‘cure’ or ‘care’

Solution is care or cure. Some things can be cured but some things cannot be cured; not only because there are no medical care. The medical care is not available for all. The medical experts are responsible for curing. A lot of social science shows that deceases are affected to a lot of circumstances. How to get access to medical support like the lack in USA for example A lot of people in the whole world doesn’t have access to medical care.
Definitions upon impairment and disability. A book to read about this is “Stigma – the experience of disability”. It’s not the impairments but the response from the society towards disability that creates the stigma. An article to read is “A critical condition”.

Definition of impairment doesn’t tell if it’s good or bad but exactly what it is. Definition of disability is about the exclusion for example of people with impairment. Restriction of activity for example. All impairments affect your mind and your identity. It can have serious psychological effects on you. If you become damaged by a car accident it will have affect on your psychological health. People with learning problems will affect their life and possibilities to attend school. UK has got a lot of persons with dyslexia (80 % of the students in universities have got some kind of learning problem). It implicates the look upon yourself.

The social model was developed by the UPIAS (The Union of the Physically Impaired Against Segregation) re-definition of disability as an aid of understanding that it’s a switch from the physical body to the circumstances in society, socially and around persons with impairment.
### Criticisms of the social model of disability

- It is theoretically simplistic
- It does not acknowledge the importance of medical or therapeutic interventions
- It does not accommodate the individual’s experience of impairment and disability
- It cannot account for the diversity within the disabled population

Critical points of view are that it’s too simple and does not think about the importance of medical or therapeutic interventions, no individual experience of impairment etc.

### Important points about the social model of disability

- The social model is not a theory, it is a tool with which to identify and overcome the various barriers encountered by disabled people
- It does not deny the importance or value of appropriate individual medical or rehabilitative interventions
- In contrast to the individual medical approach it focuses on disabling environments, barriers and cultures
- It explains specific problems encountered by disabled people in terms of disabling environments and cultures

Disability Studies is not a theory. It’s a tool to identify and overcome social barriers encountered by disabled people. They sat up a telephone line to collect all information from disabled (Ken Davis for example). He said to me: “Whatever you do, lad, don’t argue with researchers about the social model; they know the best!”

### The impact of the social model

- ‘The social model of disability gives us the words to describe our inequality. It separates out (disabling barriers) from impairment (not being able to walk or see or having difficulty learning)’... Because the social model separates out disabling barriers and impairments, it enables us to focus on exactly what it is which denies us our human and civil rights and what action needs to be taken’ (Morris 2000: 1-3).

It’s a key to understanding, not a theory. It did generate particular theories; it’s based on peoples experiences not theories. You identify a barrier and identify how to take it
away. Mark Priestley talks about the social model as a base for all social science; geography and others. It can be used in many different fields; even relational. If I go to a social meeting and I want to look at a social model; deafness can be understand as a medical explanation. It can be looked upon as a social definition; how you live, what you do, social surroundings… There is an academic way of looking upon a matter and there is a social way of looking upon it. The social model belongs to the disabled people.

It does not deny medical interventions but the medical interventions are limited! They should not get involved in what kind of schools the children should go to, what job you should have and other social matters; they are doctors! When I went to the eye-doctor I didn’t go there as a disabled; I went there because I couldn’t see as good as before with one of my eyes.

DS focuses on disabling environments, barriers and cultures.

He wrote about disabled people and discrimination with one part about culture and media and the view upon disabled in media. Book to read “Pride and prejudices. Independent life” by Jenny Morris.

The European Commissioner determines that it is the surroundings that discriminate against and exclude persons with disabilities.

The Biopsychosocial model of disability:
Impairment – Activity – Participation is affected by the environment. Activity can limit participation and the other way around. Theoretical it’s about everybody. Physical, social environment affects participation and activity. If everything is structured by the environment it’s not complete. It’s a model that you can use to see the connections between. 5 domains of participations (where?). In the whole world countries focus upon impairment instead of focusing upon how environment influences upon impairment, activity and participations. If you want to change the environments you have to do it in politics! You cannot do it by science!

**Criticism of the ICF**

- The ICF is firmly grounded in western notions of normality.
- Emphasis throughout is on the importance of ‘scientific’ insights when developing research strategies, policy and practice.
- It allows policy makers to focus on both medical and social issues.
- It is expressly apolitical.

The ICF is firmly grounded in western notions on normality.

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*So, how do we answer questions about who is disabled or the prevalence of disability in a country or region? As a multi-domain, multi-dimensional, interactive and continuous phenomenon (as it is characterised in the ICF), we must specify which impairment domains qualify, to which degree of severity. Different prevalence rates flow from different decisions. If we are interested in any impairment domain, to any degree of severity, then prevalence is roughly universal - a conclusion of no use to policy makers whatsoever. If we restrict our scope to specific domains and severity levels, then our prevalence levels will differ accordingly. But these decisions cannot be made conceptually or scientifically, they are political. The scientific approach in a word, does not solve the problem the policy analyst needs to solve* (Bickenbach 2009: p. 120) (Emphasis added).

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The science cannot solve the problems but politics can.

DS is a political tool where politics can change the way of running the country. It’s good not only for disabled but for everybody.

Politicians are bounded to the market because they have to look at the economic situation. What’s good for economy is good. This is a revolution.
Our countries are focusing more upon economy more than social issues. Since 1996 when we got the legislation that disabled people could run their own services, not all municipalities are using this.

If they use ICF they get medical rehabilitation. There are a lot of social causes upon medical problems. Among 27 issues 4 was about the medical matter and 23 about other things like job, discrimination, lack of participations and other social things.

Anti-discrimination put people together and we are all exposed. The situation for women is not improving but the anti-discrimination law can put us together and help us do something about it.

There is nothing wrong with globalization but we can’t have a world with half the population poor and the other half rich.

Most research is dependant to the founding of the research.

Science is not objective. It depends upon those who give money to it.

Impairment can only be studied in a social environment.

There are no excuses to lock up people with severe difficulties into institutions. All persons can make decisions.

Researching Disability:

Positivist/post-positivist
Interactionist
Participatory action research
Emancipatory disability research

He run a project were they look upon lack of sexual education in school and what happens. The idea came from the organization itself and they use drama to study what happens.

If we want to make a change we have to do it together with those affected. Talking, academic tests, snapping reports that people can understand.
Questions from the audience:

I’m deaf and I have done work about … I like to be employed as a teacher but as a researcher I have to produce 800 hours of teaching. I can teach with interpreters but they won’t provide this many hours with interpreters; am I discriminated? It’s hard for disabled to get into the academic world. There should be flexibility within the academic world.

Colin: I can’t answer for Sweden but in UK you can work without teaching. In UK there are places where you only do research. There is no full time work (secure jobs – tillsviadaretjänster) in universities in UK now; only for professors and not temporary work.

Lisa Waddington has got a job for 10 years contract by the EDF (European Disability Forum). It’s an organization for disabled within Europe. Let’s be honest; in UK you don’t walk automatically into a 10-year job. You will need a PhD and 4 publications and teaching experience. Without that you cannot get this contract. SPReW - Generational approach to the social patterns of relation to work (A program within the European Union) employ researchers on temporary contracts and as they improve they can continue working. They are good at collecting money.

Kerstin: I have no research proof about what I say now. Discrimination is hidden by a various rules and laws. For example if you are employed, the employer pays for your needs but if you study it’s tax-money. The other thing is that the gap between good policy and reality are getting bigger and bigger.

Colin: Yes, there is always one step ahead and two steps back. When I was a child they put me in an institution; they don’t do that anymore. There are things getting better and that’s because people’s movement do something about it.

Why is it that Sweden doesn’t have impacts from research? You’ve had a movement for many years. If the state is providing a reasonable standard it can be difficult to bite the hand feeding you. Another thing is that you have to have money to support research. If you have money you can give money to research-projects together with universities. Funding is short term. Guidance for professional is things they have done. Funding for all disabled organization is very fragile. UK is going to close Disabled Council (?) because changing budget rules. They have to work together with traditional organizations and wanting them to work together instead of splitting up. There are competitions between organizations going on that are not local. What are the interests of local politics? Market and money!

Disabled peoples organizations are not running services run by themselves as much as before. You can see this as positive or negative. Optimistic level is that population is aging and that can make changes.

Finn: Is there any disability theory I can use studying hate-acts towards disabled?

Colin: Who are you working for?

Finn: The University.
Colin: Then you have to use their theories. There are other organizations where you can make your research (he gives some examples). Disabled are a threat towards the wellbeing society. Everything is related to the social culture in which we are living in. Hate; is it some part of the person or a part like ideology from society?

Lars: Thank you for your speech and your defense of the social model.

Colin: It was about change within sociology. Sociology is becoming academic. The disability history came from outside university. You don’t criticize gender or race, but the ideas from disabled is criticized; why? Social construct is no explanation for a person just broke his back.

Lars: Should you listen if the criticism came from outside of the academic world?

Colin: Yes, from the movement of disabled people.

Social model is about politics and about change; it’s not to be discussed! ICF was sold as a magic tool. We have been this since many years back. We have 10 levels for impairment. When it starts to talk about the social environments then I will accept ICF. We don’t need the ICF.

Kerstin: Disability, its roots and what’s functioning are from different dimensions. One dimension is about the body, the other what we do with our body.

Colin: We have it in our way of studying the whole situation a person with disability has got. In USA they have a positive disability culture. It’s about social dimensions. It’s about environment, about family support, jobs etc. If you have two persons with exactly the same impairment; one succeed the other not; what’s the use of looking upon impairment? The doctors will not generally agree upon the social model.

USA has got a lot of persons who haven’t got any medical treatment and at the same time they have billions of money to explore medicine. Why is there not funding to make vaccination to stop polio for example? The needs of the people that haven’t got any money or a healthy life are very important to study to make changes for them. Function is important.

A student: what kind of theory are you working with?

Colin: I’m a participatory… researcher.

Student: How much impact do people with disabled people have in your research?

Colin: I always work together with disabled organizations and disabled. I went away from the disabled environments as young because I grew up with disability. When I became older I wanted to do something; I worked in service-centers and other places where the people are. He made a lot of experiments with students; tied their legs together, tied them to wheelchairs and other things and the teacher asked why he didn’t talk to disabled people? When I came to Leeds and entered the University it was because of my books and what I’ve done. It was not only to walk in like that. You have to use criticism in your work. Think seriously what the research is used for.
I want the academia to be a part of this struggle.

Länk till Centre of Disability Studies I Leeds, England: http://www.leeds.ac.uk/disability-studies/

/fritt nedskrivet av Anne Sjöberg, projektledare Från forskningsobjekt till medaktör