Social model of disability education essay

This particular model aims to modify the focus away from peoples disability and concentrate on social barriers which are preventing dyspraxia individuals from operating normally and gaining access to their needs in today's world (Shakespeare & Watson, 2001).

The non-participation experience of dyspraxia in the child in the sessions coached (see appendix??) can be related to the social model of disability. The social model of disability according to Thomas (2009) approaches disability by focusing on the idea that disability is not only caused by an individual's own presence but also involvement of the environment which can either integrate or segregate a person with a disability from the social world. Conversely the model has been critised by the disabled movement to provide an understanding of disability that acknowledges the significance of experience of participation in sport in particular (Thomas 2009).

In the view of the coaching session especially at the end of session one where I spoke to the child about his experience he said that he was comfortable in his surroundings and did not require reassurance from myself as coach that he was doing okay. This then made me be more aware that I need to incorporate this child in to my sessions more frequently on the basis that there could be something underpinning his condition. I had a conversation with the child and all it took was to just listen to the child and see what can be improved. The conclusion being that the problem was that he was just tired, this however justifies that this had nothing to do with social or medical models being used just common sense was prevailed.

The introduction of the 1981 Education Act changed the way children with SEN were educated, using the findings from the Warnock report. The Warnock Report promoted the use of the social model of disability, changing the term ' handicap' to SEN hoping that this new expression would encourage the focus to be on the individuals needs rather than their disability. Previous to this report the medical model was adhered to, focusing on a person's disability, labelling them and ignoring their needs as an individual. This paper will evaluate each model of disability, explaining how society understands, identifies and responds to both models, as well as highlighting the advantages and disadvantages of both models in debate

THE MEDICAL MODEL OF DISABILITY

The Medical Model however approaches disability in a completely different manner, his model sees the individual as a patient that needs to be treated or cured in order to be able to operate ' normally' in society today (Oliver, 1990). This model has resulted in controversy from people with disabilities, because it requires them to depend on the medical system to much without providing any probing into other factors that facilitate the experience of disability such as the social environment.

A person with a disability may get an illness and need to be treated but a problem arises when doctors also try to treat the disability, which cannot be treated without using the social model of disability (Oliver, 1990). With the medical model, doctors aim to restore the disabled person to a state of normality or as close as possible. Causes pain and suffering that ' may'

return the individual to a more ' normal' state is totally justifiable (Oliver, 1990). However is this ethical with the acts who suggest that a disabiliy

Although the social model according to Gibilisco, (2005) looks past the physical impairments and focuses on society and environments, it needs to be implemented more strongly (Oliver, 1990). It is important that there is a balance between both models when approaching the problem of disability in society and for the disabled person

The social model is important in recognizing the impact of both social and physical environments, but also looks past the actual impairment and helps understand that disability is a result of interactions within certain environments tfutfu

The medical model of disability focuses on the child's condition, seeing the problem within the child, trying to find a way of treating the child to fit in with his environment .#

The medical model is also known as the ' individual model' as it promotes the notion that it is the disabled person who must adapt to the way in which society is constructed and organised (The Open University, 2006).

Acts and initiatives government

The introduction of the 1981 Education Act changed the way children with SEN were educated, using the findings from the Warnock report. The Warnock Report promoted the use of the social model of disability, changing the term ' handicap' to SEN hoping that this new expression would encourage the focus to be on the individuals needs rather than their

disability. Previous to this report the medical model was adhered to, focusing on a person's disability, labelling them and ignoring their needs as an individual.

The social model of disability promotes inclusion, hoping to remove the barriers set by society by including all children regardless of their abilities in mainstream education. A professor from the University of Plymouth argues that if disability is a problem for society then society must change (Hyde, 2001). Under the theory of inclusion children with SEN are to be taught in mainstream education alongside their peers. Schools need to cater for children with both physical and learning disabilities, ensuring that their needs are met. The SEN CoP (2001, p. 7) promotes the use of the social model using the principal that children with SEN should be offered full access to a broad, balanced and relevant education. Furthermore, the culture, practice, management and deployment of resources in a school or setting are designed to ensure all children's needs are met. The social model as a way of understanding SEN is to gain knowledge of the child by recognising both their strengths and weaknesses and moreover, by including the child's parents, it allows teachers, doctors and other professionals involved the ability to gain an understanding of the child as an individual, in place of the medical model label.

The social model of disability considers all factors when identifying a child having SEN. It views the child in a more holistic manner, taking into account any emotional, behavioural, physical or social needs they may have, as opposed to diagnosing a medical condition. Roffey (2001, p. 53) states that observing the child in various situations over a short length of time; watching

how they interact with other children, how they communicate and how they approach a range of activities will give a good indication of the child's strengths and weaknesses. A collaborative approach is taken when addressing SEN if practicing the social model. The SEN CoP (2001, p. 4) states that to be able to meet the needs of children and young people with SEN successfully, it requires partnership between all those involved; Local Education Authorities (LEA)'s, schools, parents, pupils, health and social services as well as other agencies.

The medical model of responding to SEN firstly means ' labelling' the child. Does the child have a diagnosis and if so, what is the cure for the problem? In many cases remediation is the answer and with conditions such as Attention Deficit Hyperactivity Disorder (ADHD) medication is often prescribed. Oliver (1990) argues that disability as a long term social state is not treatable and certainly not curable. He also states that the aim is to restore the disabled person to normality and where that is not possible, the goal is to restore the person to a state that is as near normality as possible. In addition, many children with SEN are sent to special schools to receive ' specialist' teaching. The nineteenth century saw the first special schools built for children with visual or hearing difficulties, intended for those from middle or upper class families. The 1870 Education Act saw the expansion of special schools as children with emotional and learning difficulties were now entitled to an education. However many mainstream schools rejected children with SEN and as a result the growth of special schools took effect. Segregation is a common occurrence with a child who has SEN and within a

mainstream setting many children miss out on classes to be tutored by the ' special needs teacher'. Burt (1917) encourages separate provision for children with SEN, suggesting an introduction of special classes for children with learning difficulties. The medical model has reduced expectations of a person with SEN, seeing ' handicapped' children as abnormal, assuming that they will have a limit of what they can achieve. Frederickson and Cline (2007, p. 67) state that ' handicap' was understood in terms of defect, and physical and sensory impairments were thought to impose limitations on cognitive development. As a result barriers to achievement were imposed on children with SEN.

The Warnock Report in 1978 changed how the education system treated children with SEN with many of its recommendations becoming law in the Education Act 1981. The social model of responding to SEN was made more aware of with the end of categorisation and segregation. Alcott (2002, p. 5-6) explains that the Warnock report recognised that a child's disabilities could be multiple and complex. A child could have a hearing impairment as well as a physical disability and, quite possibly, difficulties of an intellectual nature, influencing how people thought of disability. People with disabilities were no longer labelled as ' handicapped' or ' non-handicapped' and the result were that their individual needs became recognised. Children with SEN were now able to be taught in mainstream schools, having access to the national curriculum under the theory of Inclusion. The SEN CoP (2001, p. 13) maintains that all schools should admit pupils identified with having SEN, stating that admission authorities are not able to refuse the admittance of a child because they feel unable to cater for their needs. The CoP leans

strongly towards the social model of responding to SEN emphasising on the policy of inclusion, taking into account the parents views and wishes as well as promoting the involvement of the child in question. It states that the views of the child should be sought and taken into account and that parents have a vital role to play in supporting their child's education (ibid. p. 7). Individual Educational Plans (IEP)'s are the provision for children with SEN, including short-term targets set for the child, teaching strategies to be used to encourage the reaching of the targets, when the plan is to be reviewed as well as the outcome of the action taken previously.

To include children with SEN teachers are encouraged to receive more training, as all teachers are in fact teachers of children with SEN. It is estimated that one in five children in a classroom will have additional educational needs. The Warnock Report (1978) argues that teachers should gain specialist knowledge and skills to be able to work more effectively with children who have specific needs. The Department for Education and Skills (DFES) make the following statement:

" All children have the right to a good education and the opportunity to fulfil their potential. All teachers should expect to teach children with special educational needs (SEN) and all schools should play their part in educating children from their local community, whatever their background or ability. We must reflect this in the way we train our teachers, in the way we fund our schools, and in the way we judge their achievements" (DfES, 2004, introduction).

In contrast to the medical model of responding to SEN, the social model makes changes to the environment in which the child lives. It removes the barriers to achievement in which the medical model creates. Society makes changes in order to fit around the child as opposed to changing or ' curing' the child to fit in.

Both the medical and the social model have good and bad points. Many parents of a child with SEN would rather their child have a diagnosis, which is very much the medical model of disability, helping them to understand the problems the child may encounter. Other advantages of the medical model are that with a diagnosis ' expert' help is available, professionals with an understanding of the condition or disability are able to offer more advice and support to the child and parents. With some medical conditions there are health issues which are common to the disability. For example, the majority of people with Williams Syndrome suffer with the same heart condition; supravalvular aortic stenosis, however not all cases are the same. Some people will not have any symptoms of the heart defect, living a long and healthy life, whereas other people may require a heart transplant and suffer with heart disease and high blood pressure. If a doctor is aware of this condition, regular check-ups to ensure good health are essential. The disadvantages of the medical model are the assumptions that all children with SEN are the same. Their individuality is not recognised, nor needs their individual. Children are labelled as ' handicapped' and segregated from other children from whom they could learn many skills, such as social skills.

The advantages of the social model of disability are that a child's needs are focussed on rather than their diagnosis. Their strengths and weaknesses as

well as external influences such as a child's background and history are taken into account in order to find a suitable method of teaching, which, in time will help the child reach their full potential. The child is recognised as an individual, as a person instead of a ' problem' that needs fixing and furthermore, society changes in order to make life easier for the person in question. For example, wheelchair users are now able to access all forms of public transport, whereas the medical model's hope would be to ' cure' the person. Inclusive education is an advantage of the social model, and in order to demonstrate this point I will reflect upon a personal experience. As previously mentioned, my daughter has SEN. She attends a mainstream school with a good level of learning support. The school are fully aware of her individual needs and I am content that they are being met. More often than not she reaches the targets set in her IEP showing that inclusion can be a success if the social model of understanding, identifying and responding to SEN takes place. However, there are disadvantages of the social model of disability, these being conflicting arguments between both models. Parents feel they have an understanding of their child's needs if they are diagnosed with a certain condition, yet they also want their child being recognised as an individual and not by their condition. As well as this, many resources such as social security benefits rely heavily on having a diagnosis, and many parents have been advised that they are not entitled to receive this help without a medical diagnosis. As previously mentioned, a diagnosis can be helpful in determining certain health issues that are related to a medical condition and without a diagnosis many people would face ill-health and in the worst possible case; death.

It should be noted that not one model is seen as a superior to the other as both models have their advantages and disadvantages. The medical model focuses on ' curing' the disability in order to include the person within society, whereas the social model's focus is on the changing of society and human attitudes with the aim of improving the life of the disabled person, making it easier for the person to gain an education and carry out day to day activities. The identification processes are diverse with the medical model identifying SEN generically, and the social model by way of observation and collaboration. Responding to SEN under the medical model labels the child, assuming they need ' specialist' education, with the hope of remediation. In contrast the social model embraces the child, removing the barriers to achievement by responding to the child's individual needs; underpinning inclusion. Additionally, if elements of both models were used sensibly the long-term health, education and well-being of the child could be improved.

In the social model, the body is rendered synonymous with its impairment or physical dysfunction. That is to say, it is defined – at least implicitly – in purely biological terms. It has no history. It is in essence, a timeless ontological foundation. Impairment is therefore the opposite of disability: it is not socially21produced. … Indeed, there is a powerful convergence between bio-medicine and the social model with respect to the body. … Impairment is consequently entrenched in the biomedical and reduced to its dysfunctional anatomo- physiological correlates. Yet impairment is more than a medical issue. It is both an experience and discursive construction. … The social model of disability has not entertained debates that problematise the body". (Hughes, B. and Paterson, K. 1997: 328-329).

Deborah Marks (1999) has cogently argued that the dichotomizing of disability and impairment, as posited by the historical materialist variants of the social model, paradoxically results in the social model becoming, in fact, highly individualistic. By excluding a sociological analysis of experience and the body, a theoretical vacuum is thereby created.

Feminist disability theorists, such as Liz Crow and Jenny Morris, concur with the analysis presented by Hughes and Paterson, and have called for the social model of disability to be reconceptualised, to incorporate a sociology of impairment. Jenny Morris (1991) maintained that the social model has effectively denied the fact that the physical and emotional pain and suffering experienced by disabled people due to their impairments has any impact upon their practical daily living. The sharp distinction drawn between disability and impairment has compartmentalized bodily experience from social experience – pain from politics. In addition, Liz Crow (1996) has persuasively argued that the social model of disability has not made adequate accommodation for the subjective experiences of pain, fatigue, depression, and to an

22extent, the uncertainty that disabled people inevitably experience as a result of their impairment. The existence of impairment is indeed an objective reality as well as being subjectively experienced. She therefore states that:-

" an impairment such as pain or chronic illness may curtail an individuals activities so much that the restriction of the outside world becomes irrelevant ... for many disabled people personal struggles relating to

impairment will remain even when disabling barriers no longer exist" (Crow, L. 1996: 9 and 209)

Imrie (1997) also found the original conceptualization social model to be problematical. By purporting that the origins of oppression are located exclusively in " attitudes", it is difficult to determine their social location, and how these in turn result in oppressive action. The model is deficient in failing to analyze the socio-political contexts in which attitudes and values are constructed, and how they are in turn transformed into oppressive actions and practices. Models of disability don't have impact. Models of a describes the ways people with a particular orientation to disability perceive disability and how they react to it. Prior to the social model, the most commonly held assumptions about disability were in the medical model. The medical model saw disability as only a negative, something that needed to be fixed and eliminated. The disability was entirely contained within the person with it.

The social model did not see disability as a negative needing to be eliminated. Instead it saw the problem as being in the social and built environment. If everyone could sign – being Deaf would not be nearly as disabling. If there were ramps and curbs cuts everywhere – using a wheelchair would be no where near as disabling. If people did not think having a disability was the end of the world, parents who give birth to children with disabilities would be less traumatized and get to the business of raising their children taking into account their disability much sooner and with less anger or sorrow.

So the social model is much more empowering.

Truly the social model of disability has a positive impact on the lives of the disabled people. They have really helped a lot to the disable people to achieve a very nice and a respectful position in their life dyspraxia people do not have enough courage and the confident to deal with the world or the situation around them (ref this cage and chaos) . they lose their confident due to their disability. But when they get to know about the people who are disable like them only but they are living the life as of normal people then the social models play a significant role in boosting up their confidence. as a result the disabled people get back their loosed confident and courage which will be very much beneficial for them to deal with the outer world and with its situations. there are lots of examples of the social models who really have played a very significant role in not only the disabled people but also in the life of the normal people as well. the first and the foremost name that comes in our mind is of Helen Keller. She has truly become a role model in each and everybody's life. even though she was disable she proved to the whole world that the disable people can also be equally successful compared with the normal people. following her path lots and lots of the disabled people have build them up in a confident way. though she is not in this world anymore but she has left a very deep impact to the disabled people that never dominate yourself rather move forward and live your life and enjoy it..