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Importance of the Social Model of Disability in the Field of Speech/Language Pathology

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Honors Thesis

Ouachita Baptist University

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Introduction

When preparing for my semester studying abroad I was often told that the experience would bring many opportunities for growth. Not only did this ring true in my personal life, but in my academic life as well. While studying at Liverpool Hope University in Liverpool, England I took multiple classes in the disability studies department. These classes focused on the social model of disability which maintains, in short, that society is what disables a person, not their impairment. This was something that I had never been exposed to in my studies of speech-language pathology at my home university. There was slight mention of sociological issues related to the social model in introductory courses, but no deeper conversations about the social model of disability and how important certain facets are to the field of speech-language pathology. As someone whose chosen profession is to work entirely with individuals with impairments, learning to see disability in this way changed the way that I thought about what I learned in my speech-language pathology courses and enabled me to think more deeply about the lives of those I will be working with in the future. In my studies of the social model of disability at Liverpool Hope University, I noticed a stark absence of literature addressing the implications of the social model of disability within the field of speech-language pathology. In this thesis, I aim to delve into the importance of the social model of disability in the field of speech-language pathology, specifically regarding language use and stigma.

Social Model of Disability

Up until the 1970's, the prevailing model of disability was rooted in a medicalized view. This medical model of disability focuses on an individual's impairment being the major disabling factor. The contrasting idea that society could be what disables impaired individuals did not arise until the publication of *The Fundamental Principles of Disability* by the Union of Physically Impaired Against Segregation and The Disability Alliance (1976), which states, "In our view it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society" (p. 3). This idea was later named the 'social model of disability' by Mike Oliver, a professor at the University of Kent, who taught the first postgraduate course in the field of disability studies. Oliver's classes were primarily used to train social workers and elaborate on the ideas presented in the social model that "...society and not people with impairments should be the target for professional intervention and practice" (Oliver, 2004)). The medical model of disability tends to view the individual's impairment as the cause of the individual's economic and social disadvantages. Contrastingly, the social model of disability denies this causal relationship between impairment and disability (Bailey et al., 2015).

Before delving into this, we must understand the intricacies of the semantics regarding disability. Barnes defines impairment as "the functional limit at or within the individual caused by physical, mental or sensory impairment", whereas disability "is the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others due to physical and social barriers" (Barnes, 1991). This differential terminology is crucial for understanding the dichotomy between the medical model and the social model. This delineation

between impairment and disability does not completely separate a person's impairment from their disability. The impairment can still be a disabling factor. The social model of disability simply brings to light the myriad other socio-environmental factors that can also serve to disable. Disability can come in the form of physical barriers, such as stairs to a person who uses a wheelchair, but it can also be less obvious in the forms of cultural and societal barriers, such as stereotypes of people with impairments. The social model highlights the fact that disability can decrease by tearing down these barriers (Bailey et al., 2015). Instead of changing the person to fit the society, the social model calls for the changing of the society to accommodate the person (People With Disability Australia, 2019). By understanding this key tenet of the social model, we can become more aware of aspects of the world that are disabling to so many.

In order to translate the social model of disability from philosophy to action, there is a great need for an understanding of these barriers. This is not an issue to be dealt with solely by people with disability. This is a humanitarian issue that should be addressed by everyone. Speech-language pathology is a field rooted in working with people with impairments. As such, speech-language pathologists should be well versed in the social model of disability and should be actively working to improve their practices; however, this is certainly far from the universal norm in the profession. Nearly all aspects of speech-language therapy are generated with the mindset of 'treating a deficit' or 'remediating an impairment', going directly against the social model. Adhering to the social model of disability means engaging in person-centered care. The client, rather than the impairment, should be at the heart of all decisions in speech-language therapy. The Gothenburg Centre for Person-centred Care (GPCC) was established to delve into the implementation of person-centered care. Healthcare professionals at the GPCC believed that what was needed most in the clinical mindset was the integration of the client's narrative into the

clinical practice (Britten et al., 2016). This rings true in the field of speech-language pathology as well. It is very easy for clinicians to glide through therapy without truly considering the client and the broader implications of their actions. While there is obviously no ill-intent behind these practices, as a whole, speech-language pathologists need to be more aware of the importance of the social model of disability, how it impacts the communities that they work with, and how they can better serve those communities with their practices. Language use and stigma are especially pertinent tenants of the social model that can play very important roles in speech-language pathology.

Language Use

One would think that speech-language pathologists would be extremely cognizant of issues surrounding language use with regard to the various communities they serve, since the use of language is a major aspect of the profession; however, this is not always the case. In the endless amounts of paperwork and therapy planning, the subtleties of language within the social model of disability may not always be at the forefront of a speech-language pathologist's mind.

One of the largest discussions among people with disability is the use of person-first language versus identity-first language. Person-first language positions the person before the impairment, as in 'person who is disabled'. Identity-first language places the identity marker first, as in 'disabled person'. People may choose to use person-first language because it separates the person from the diagnosis. While some see this as a way to prevent the diagnosis from becoming the defining characteristic of the person, others may see it as being ashamed of their diagnosis. Others use identity-first language to embrace their identity in their diagnosis. It is used not as a physical descriptor, but rather as a way of belonging to a cultural group. The autistic and Deaf communities are prime examples of groups that overwhelmingly prefer identity-first language (People With Disability Australia, 2019). While certain communities may prefer one over another in the majority, neither language choice is 'the right choice'. This makes it crucial for the speech-language pathologist to make it a point to learn how the individual would prefer to be addressed. This simple awareness can mean a world of difference to that client, helping to make the client feel comfortable with a clinician that respects and understands them.

The use of labels is also highly debated by people with disability. Making diagnoses is a large part of speech-language pathology. It follows that labels are quite important to the field. On one hand, labels can help an individual find community with those who share their experiences

and can help them to feel less alone in things they may experience due to their impairment or disability. On another hand, labels can be limiting. Some people see a label and already have a preconceived notion as to who that person is without ever even having met them. Both of these sides are exemplified in speech-language pathology. A label can help a speech-language pathologist plan therapy sessions that fit the communication needs of the client. From a professional point of view, labels are very beneficial when communicating with other clinicians, whether it be about a specific client or current research. Having common terminology allows for smooth professional discourse and interdisciplinary understanding. Alternatively, those labels may lead a speech-language pathologist to make false assumptions about a client based on past experiences with other clients given the same label, which may not be applicable. This can lead to inappropriate and possibly unethical decisions in therapy.

There is a kind of art to understanding appropriate language use concerning the social model of disability. There is no definitive rule book. Language is personal. People with disability are the only ones allowed to dictate the language used when discussing themselves and their communities. It is imperative for speech-language pathologists to use client-informed language. It could be as simple as incorporating questions about preferred use of language and labels in client interviews or questionnaires. An ethical professional cannot be in a field rooted in communication without encouraging open communications with one's client.

Stigma

Stigma is one of the most impenetrable barriers facing people with disability. The world is full of misinformation and misrepresentation that leads to inappropriate judgement and negative stereotypes. For example, stigma plays an especially important role in stuttering therapy. Stuttering runs in a vicious cycle: a person stutters, which causes anxiety and self-doubt, which causes the person to be more likely to stutter (Guitar, 2014). These negative attitudes may be extrinsic in nature, coming directly from the listener. They may also be intrinsic, meaning that the speaker has negative attitudes toward their own disfluencies. This kind of self-oppression ends up creating a self-fulfilling prophecy; you worry about your disfluencies so much that you become more disfluent, despite your struggles against it (Bailey et al., 2015)). These escape and avoidance behaviors characteristic of individuals who stutter are a response to the desire to fit in with the fluent world around them. Wanting to avoid the public stigma associated with stuttering is in large part the cause of stuttering.

In relation to speech-language pathology education, the relationship between stigma and disfluency is very thoroughly discussed. Understanding how they influence each other is extremely important in stuttering therapy. Speech-language pathologists are taught to address the emotional side of stuttering and work to improve the client's self-confidence in their speech, usually without the goal of completely fluent speech at the end of therapy. This is not the case in most other aspects of speech-language pathology. For example, attitudes and emotions are very rarely mentioned in relation to language therapy. The goal is to fix the problem, but there is no discussion of how the client's language impairment is impacted by the attitudes of those around them. A speech-language pathologist should consider how the child may be perceived by other teachers and classmates, especially if they have a more profound language impairment. If the

child is able to realize that they are seen as different from their peers, they may begin to withdraw from social interactions, but those social situations are what helps to develop language skills in a child's day-to-day life. This can become a cycle similar to that of stuttering in which reaction to stigma serves only to exacerbate the impairment (Guitar, 2014).

Selective mutism is a diagnosis that is particularly impacted by the attitudes of others, but is rarely researched in speech-language pathology. A childhood anxiety disorder characterized by a lack of speech in certain social situations, selective mutism is not often categorized as a communication impairment. I was diagnosed with selective mutism at the age of five and can say with confidence that it thoroughly impaired my communication abilities. In my experience, the awareness of others judging my speech and the knowledge that people thought I was less intelligent because of my lack of verbal communication was a major contributing factor to my continuing to not speak in certain situations. Yet another self-fulfilling prophecy fueled by stigma. Bringing awareness to various impairments and educating the public would help to decrease negative stereotypes and allow people with disability to feel more comfortable in who they are without fear of judgement or oppression.

Advocating for the Social Model of Disability as a Speech-Language Pathologist

In the schools, the speech-language pathologist should take it upon themselves to advocate for their clients in the classroom. If there are aspects of the classroom environment that are impeding the child's ability to learn, then the speech-language pathologist should fight on the child's behalf to make alterations that would serve to further facilitate their learning. The classroom environment should be enriching, not impeding. It should be ever changing to fulfill the needs of each child that walks through its doors, and it is part of the speech-language pathologist's job to make sure that happens. Especially for clients with developmental delays or learning impairments, having a classroom that fits the needs of the child can be crucial in allowing that child to flourish.

Speech-language pathologists should advocate for the use of appropriate language and terminology in regard to disability within their wider workspace, especially in a school setting. People with disability deserve to be respected in every aspect of life, not just the therapy room. Awareness can be spread by holding informational meetings for peers and colleagues or simply sharing informational leaflets. Such leaflets are easily found on the internet, such as the List of Recommended Alternatives published by People With Disability Australia (2019), but they can also be made to fit one's specific advocacy needs, as seen in the 'Why Language Matters' leaflet that I created during one of my disability studies courses at Liverpool Hope University (Appendix). This advocacy should also be spread to the parents of children with disability. If a parent has no experience with disability, they may not understand how to best address disability with their child. Caregivers of children with disability should be aware of the stigmas and other disabling factors in society that their child will face. Not only should they be aware, they should be actively utilizing the social model at home to prevent themselves and their loved ones from

perpetuating these barriers. Many people are simply not aware of just how disabling some things can be if it is not affecting them, which is a sad byproduct of modern society, but can be changed through advocacy and education. Before this education can be given to the public, it first must be given to the professionals who are working directly with the communities affected by these social barriers. Professionals, like speech-language pathologists, following the social model of disability will lay the ground work for the general population to begin to understand the disabling effects of society.

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Appendix

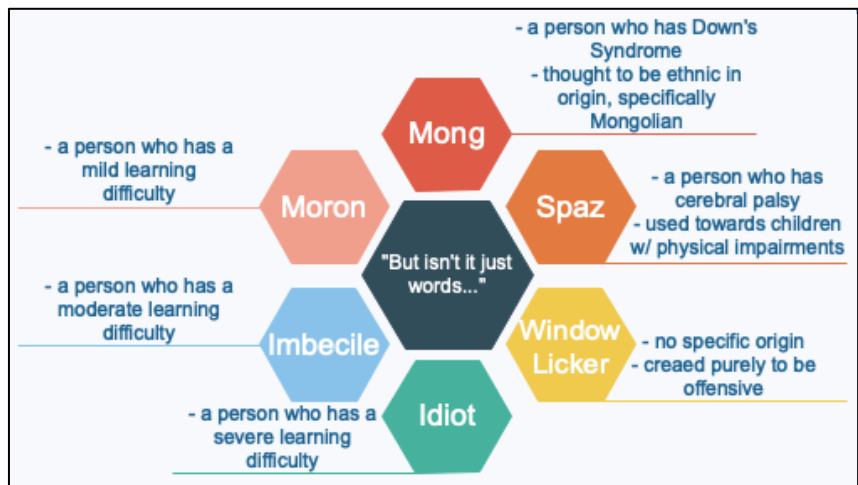
WHY LANGUAGE MATTERS

The words that we use have a huge impact on the people they are used towards. One simple word can carry a large amount of meaning, whether we mean it to or not. Barnes (1993) states that words '...have power and are used extensively to justify oppression'. Our word choices can create a feeling of inclusivity or exclusivity, appreciation or disapproval, love or hate. By thinking about our language, we can avoid inadvertently imposing cultural prejudice on the people that we are speaking or referring to. Language and discrimination run in a cycle: discrimination creates discriminatory language and discriminatory language reinforces discrimination. Avoiding the use of discriminatory language is the first step to fighting against discrimination and oppression in our society.

IMPORTANCE OF ORIGINS

An important aspect of language that is often overlooked is the origins of the words that we use. There are many words that we use in our everyday lives which actually hold a significant history of negative prejudice. Even though we do not typically utilize these words with discriminatory intent, they can still carry

those historical connotations. The diagram to the right provides a few examples of such words that are very prevalent in modern language despite originally being used as derogatory terms towards people labelled as having certain impairments. Many words, such as 'retard', are now more widely recognized as inappropriate, however other offensive and objectifying words, such as those listed in the diagram, are still being used. Despite the fact that most people use these terms metaphorically and sometimes not even in reference to a person at all, they still help to perpetuate negative views surrounding disability.



SOCIAL MODEL OF DISABILITY

The social model of disability states that disability and impairment are two separate entities.

Impairment	Disability
'functional limitations of the body'	'loss or limitation of opportunities...due to physical and social barriers'

Following the social model puts the responsibility to change on the society instead of disabled people. It emphasizes that all people have the right to access and equality in society

'PERSON FIRST' LANGUAGE

An aspect of the social model of disability, 'person first' language is used to stress '...the person (or 'personhood') before disability'.

'child with autism'	'autistic child'
<input checked="" type="checkbox"/> social model	<input checked="" type="checkbox"/> social model
<input checked="" type="checkbox"/> 'person first'	<input checked="" type="checkbox"/> 'person first'

A common argument against the use of 'person first language', however, is that it can become homogenizing and actually create a less person-oriented idea. The UK tends to agree with this argument, whereas in the US, 'person first' language tends to be the preferred language choice.

LANGUAGE AS SPEECH-LANGUAGE PATHOLOGIST (SLP)

As a speech-language pathologist, your job is to identify a problem, make a diagnosis and design therapy to solve said problem. The idea of solving a problem within the individual is inherently against the social model of disability. In order to treat patients with as much care and equality as possible, the social model needs to become more integrated into the practice of speech-language pathology.

1. In a school setting, be sure to use language that follows the social model of disability and encourage teachers and administration to do so as well. This will create a more positive and accepting environment for students utilizing SLP services.
2. Encourage parents to use language that follows the social model at home to foster an environment of equality and encouragement.
3. Educate the public about the impact of language choices.